# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The Division of Medicaid (DOM) strives to provide quality home and community-based services (HCBS) in the least restrictive environment possible. DOM chooses to expand this waiver to include a Participant-Directed personal care service which allows employer and budgetary authority for participants to manage their personal care attendants. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a Financial Management Service (FMS) agent to assist with employer and budgetary functions. The waiver participant will have the ability to negotiate salaries and benefits with the personal care attendants while the FMS agent manages functions including but not limited to, time sheets, criminal background checks and other employment issues

The traditional personal care service choice, otherwise known as the Co-Participant personal care service, remains a viable choice for those waiver participants who do not desire to be become the employer of record with budgetary control. The Co-Participant choice for the personal care service recognizes Mississippi Department of Rehabilitation Services (MDRS) as the employer of record but allows the participant to recruit, hire and terminate employment of PCAs. The Co-Participant personal care service does not allow the participant to exercise budgetary authority (excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance).

The FMS is a new support service for the Participant-Directed personal care service providing assistance to the waiver participant with management of the personal care service budget and employer duties as associated with the participant being the employer of record. The FMS will submit claims for personal care services to DOM for payment and is responsible for assisting the participant with including, but not limited to, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance. This choice provides more autonomy and independence for the waiver participant.

An additional change for this waiver involves expanding the Medicaid eligibility requirements to include the working disabled. Eligibility for the waiver will be determined by Medicaid regional offices which are located throughout the state.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A.** The **State** of **Mississippi** requests approval for a Medicaid home and community-based services (HCBS) waiver under

the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**Independent Living Waiver**

**C. Type of Request:renewal**

**Requested Approval Period:***(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: MS.0255**
**Waiver Number:MS.0255.R04.00**
**Draft ID: MS.02.04.00**

**D. Type of Waiver** *(select only one):*

Regular Waiver

**E. Proposed Effective Date:** *(mm/dd/yy)*

07/01/12

**Approved Effective Date: 07/01/12**

## 1. Request Information (2 of 3)

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

The participant must:
1) Exhibit severe orthopedic and/or neurological impairment that renders the participant dependent on others, assistive devices, other types of assistance, or a combination of the three to accomplish the activities of daily living.
2) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, counselors/case managers, or others involved in their care.
3) Be medically stable. Medical stability is defined as the absence of any of the following: (a) An active, life threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); ( b) IV drip to control or support blood pressure; (c)intracranial pressure or arterial monitoring.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

- [ ] **§1915(b)(1) (mandated enrollment to managed care)**
- [ ] **§1915(b)(2) (central broker)**
- [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
- [ ] **§1915(b)(4) (selective contracting/limit number of providers)**

- [ ] **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**
Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of this waiver is to provide cost-effective in-home support services to participants aged 16 and older who, but for the assistance provided by this waiver, would require institutionalization in a Nursing Facility.

The goal of the Independent Living waiver is to provide participants seeking Long Term Care assistance, meaningful choices to allow residency in the HCBS. The waiver strives to identify the needs of the dependent participant and provide services in the most cost efficient manner possible with the highest quality of care. This is accomplished through the utilization of a Preadmission Screening (PAS) process that provides a single point of entry concept for individuals seeking long term care services and is designed to fill two primary functions: 1) determine eligibility for Medicaid long term care across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services.

This waiver is administered by the DOM (otherwise known as the State) and operated statewide by MDRS (otherwise known as the Department) through an interagency agreement. The following are services that are provided under the IL Waiver: case management, personal care attendant service, financial management, environmental accessibility adaptation, specialized medical equipment and supplies, and transition assistance.

Upon entry into the waiver, the waiver participant will choose between two options for delivery of personal care service.
1) The traditional personal care service, otherwise known as the Co-Participant personal care service, remains a viable choice for those waiver participants who do not desire to be become the employer of record with budgetary control. The Co-

Participant choice for personal care service recognizes MDRS as the employer of record but allows the participant to recruit, hire and terminate employment of personal care attendants. The Co-Participant personal care service does not allow the participant to exercise budgetary authority (excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance).

2) Participant-Directed personal care service allows employer and budgetary authority for participants for the personal care service. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a FMS agent to assist with employer and budgetary functions. The waiver participant will have the ability to negotiate salaries and benefits with the personal care attendants while the FMS will assist the participant with, including but not limited to, the time sheets, criminal background checks, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E.** **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F.** **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G.** **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H.** **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I.** **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J.** **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A.** **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B.** **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

**C.** **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board

except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:
DOM actively sought public input during the development of this waiver renewal by seeking comments, conducting group meetings, and meeting with providers and stakeholders. Greater than 90 days prior to submission of the waiver renewal application to CMS, the Mississippi Band of Choctaw Indians was notified via certified mail of the renewal process for this waiver. A formal request was made for participation in the renewal process with encouragement to provide comments about the waiver document. Prior to submission of the waiver applications to The Centers of Medicare and Medicaid, draft copies were sent to the Choctaw Tribe for review and comments. A face-to-face visit was made to the Reservation to discuss the waiver renewal process and proposed chages with Tribal respresentatives.

Mississippi also obtains public input through the IL waiver review and audit process. A DOM HCBS review team regularly audits each HCBS waiver case management and service provision. This process includes participant home visits to a sample population being served in a particular area. During this home visit, direct feedback is received from the waiver participant and /or their family members. Specific feedback is obtained regarding the participants' satisfaction with their services, their satisfaction with their case manager/counselor, any additional services that they believe that they could benefit from. This feedback is utilized to improve and/or further develop waiver services. Another mechanism through which public input is obtained is through calls from waiver participants, family members or applicants regarding inquiries, complaints, or appeals.

Waiver administrative staff consulted with other States to determine best practices with waiver services and functions.

Stakeholder meetings were initiated 6 months prior to submission of the waiver documents to The Centers of Medicaid and Medicare.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal

Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K.** **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Ricks

**First Name:** Ann

**Title:** Bureau Director

**Agency:** Mississippi Division of Medicaid

**Address:** Walter Sillers Building, Suite 1000

**Address 2:** 550 High Street

**City:** Jackson

**State:** **Mississippi**

**Zip:** 39201

**Phone:** (601) 359-6697 **Ext:** ☐ **TTY**

**Fax:** (601) 359-9532

**E-mail:** Ann.Ricks@medicaid.ms.gov

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Browning

**First Name:** Shelia

**Title:** Deputy Director

**Agency:** Mississippi Department of Rehabilitation Services

**Address:** 1281 Highway 51 North

**Address 2:**

**City:** Madison

**State:** **Mississippi**

| | |
|---|---|
| **Zip:** | 39110 |
| **Phone:** | (601) 853-5209 **Ext:** ☐ **TTY** |
| **Fax:** | (601) 853-5301 |
| **E-mail:** | sbrowning@mdrs.ms.gov |

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

| | |
|---|---|
| **Signature:** | Phyllis Williams |
| | State Medicaid Director or Designee |
| **Submission Date:** | Jun 15, 2012 |

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

| | |
|---|---|
| **Last Name:** | Williams |
| **First Name:** | Phyllis |
| **Title:** | Deputy Director of Medical Services |
| **Agency:** | Mississippi Division of Medicaid |
| **Address:** | 550 High Street |
| **Address 2:** | |
| **City:** | Jackson |
| **State:** | **Mississippi** |
| **Zip:** | 39201 |
| **Phone:** | (601) 359-5244 **Ext:** ☐ **TTY** |
| **Fax:** | (601) 359-9521 |
| **E-mail:** | phyllis.williams@medicaid.ms.gov |

## Attachments

**Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

The waiver includes a new option for a Participant-Directed personal care service. As the operating agency for the waiver, MDRS is the provider assuring this participant-directed delivery model is implemented successfully. As a waiver applicant/participant is determined eligible for waiver services, they will be given 2 choices of Personal Care Services.

1)The traditional personal care service, otherwise known as the Co-Participant personal care service, recognizes MDRS as the employer of record for the personal care service.

2)Participant-Directed personal care service recognizes the participant as the employer of record, managing both the employer and budgetary aspects of the personal care service. A FMS will be provided for the waiver participant if the Participant-Directed persoanl care service is chosen.

As current waiver participants are recertified or earlier upon request, they will be given the choice of personal care service options. Training of all personal care attendants will be provided in accordance with established operating procedures. MDRS will determine competency of all personal care attendants and during quarterly reviews ensure the participant's needs are being met. (If MDRS determines the personal care attendant does not meet established standards for the personal care service or is not competent to render care, MDRS can deny the services of the personal care attendant. The waiver participant will have the opportunity to select a new personal care attendant subject to MDRS certification of competency.

DOM has established criteria for the FMS specific to The Centers of Medicare and Medicaid (CMS) requirements. Upon notification of approval of the waiver by CMS, a Request for Proposal(RFP) will be initiated to recruit potential FMS vendors. A vendor(s) will be chosen that best meets the qualifications while meeting the needs of the waiver participant maintaining cost effectiveness. The FMS will be a waiver support service with oversight by DOM.

The enhanced eligibility provision for the working disabled will be transitioned into the waiver by:
1) Notification and training of the DOM eligibility personnel in the regional offices to consider at the time of eligibility determination.
2) Case managers will inform all new waiver participants at the point of entry into the waiver and existing participants upon recertification of the option for working disabled. Medicaid regional offices are accountable for determining eligibility of all waiver participants.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*
*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*
*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*
*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   *(Do not complete item A-2)*

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   *(Complete item A-2-a).*

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   **Mississippi Department of Rehabilitation Services (MDRS)**

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   **As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

MDRS is responsible for the operational management of the waiver on a day-to-day basis and is accountable to DOM which ensures that the waiver operates in accordance with federal waiver assurances. Responsibility is delegated to MDRS and/or monitored by DOM for 1) waiver enrollment managed against approved limits, 2) waiver expenditures managed against approved levels, 3) level of care evaluation, 4) review of participant service plans, 5) qualified provider enrollment, and 6) quality assurance and quality improvement activities and, collaboration in the development of rules, policies, procedures, and information development governing the waiver program.

An interagency agreement between the DOM and MDRS is renewed each fiscal year and updated as needed. DOM monitors this agreement to assure that the provisions specified are met.

In the agreement, DOM designates the assessment, evaluation, and reassessment of waiver participants to be conducted by qualified individuals as specified in the current waiver. Medical certification and re-certification of the need for HCBS waiver programs shall be certified by a licensed physician. All such evaluations for certification or re-certification are subject to DOM's review and approval.

DOM performs monitoring of the multi-site offices of MDRS on an annual basis to assess their operating performance and compliance with all rules and regulations. DOM registered nurses perform 100% desk reviews of all Independent Living certifications, both initial and annual recertification.

MDRS is responsible for the waiver participants assessment, evaluation, and reassessment conducted by appropriate professionals as specified in the waiver. In addition, MDRS State office management staff is responsible for initial and ongoing training of the MDRS Regional Directors, individual case manager/counselors, registered nurses, and personal care attendants.

MDRS is also responsible for the registrations and status verification for all newly hired providers and employees excluding the personal care attendants of waiver participant that opt for the Participant-Directed personal care service. MDRS is responsible for obtaining criminal back ground checks on all personnel who provide direct care to waiver participants excluding the personal care attendants working for the participant under the Participant-Directed personal care service option.

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Other State Operating Agency |
|---|---|---|
| **Participant waiver enrollment** | ☑ | ☐ |
| **Waiver enrollment managed against approved limits** | ☑ | ☑ |
| **Waiver expenditures managed against approved levels** | ☑ | ☑ |
| **Level of care evaluation** | ☑ | ☑ |
| **Review of Participant service plans** | ☑ | ☑ |
| | | |

| | | |
|---|---|---|
| **Prior authorization of waiver services** | ☑ | ☐ |
| **Utilization management** | ☑ | ☐ |
| **Qualified provider enrollment** | ☑ | ☑ |
| **Execution of Medicaid provider agreements** | ☑ | ☐ |
| **Establishment of a statewide rate methodology** | ☑ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☑ | ☑ |
| **Quality assurance and quality improvement activities** | ☑ | ☑ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**1)Number and percent of monthly enrollment reports submitted by MDRS indicating that current census and unduplicated count do not exceed estimates in the waiver.**
**Numerator: Number of monthly enrollment reports submitted by MDRS indicating that current census and unduplicated count do not exceed estimates in the waiver.**
**Denominator: Total number of enrollment reports submitted by MDRS**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**2)Number and percent of monthly waiver expenditures reports submitted by MDRS that on average are at or below the projected expenditure levels for the month. Numerator: Number of monthly waiver expenditure reports submitted by MDRS on average are at or below the projected expenditure levels for the month. Denominator: Total number of monthly waiver expenditure reports sumbitted by MDRS.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Accessible Automated Case Environment (ACCE)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**3)Number and percent of initial level of care evaluations completed by MDRS by qualified staff as specified in the waiver application. Numerator: Number of initial level of care evaluations completed by MDRS by qualified staff. Denominator: Total number of initial level of care evaluations reviewed.**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**Omnitrack**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**4)Number and percent of waiver participant service plans updated quarterly by MDRS as specified in the waiver application. Numerator: Number of waiver participant service plans updated quarterly by MDRS. Denominator: Total number of waiver participant plans.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AACE ( Accessible Automated Case Environment)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |

☐ **Other**
Specify:

**Performance Measure:**
**5)Number and percent of rehabilitative counselors/case managers employed by MDRS that were hired using qualifications as stated in the waiver. Numerator: Number of rehabilitative counselors/case managers employed by MDRS that were hired using qualifications as stated in the waiver. Denominator: Total number of rehabilitative counselors/case managers employed by MDRS.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Monthly report from MDRS to DOM**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| | |
|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**6)Number and percent of monthly reports submitted by MDRS within specified time frames ( a comprehensive monthly report is due at DOM no later than the eighth business day). Numerator: Number of monthly reports submitted by MDRS within specified timeframe. Denominator: Total number of monthly reports.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AACE (Automated Accessible Case Environment)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation** | **Frequency of data aggregation and** |
|---|---|

| **and analysis** *(check each that applies):* | **analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**7)Number and percent of providers enrolled by the FMS that met provider qualifications prior to performing services for members choosing self-direction. N: # of self-direction service providers that met qualifications prior to performing services; D: # of self-direction service providers enrolled by the FMS**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**8)Number and percent of payroll functions reported monthly by the FMS that were submitted on time and in the correct format as specified in the agreement with DOM/MDRS. N: # of payroll functions reported monthly by the FMS that were submitted on time and in the correct format as specified in the agreement with DOM/MDRS D: Total # of payroll functions reported by the FMS**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**9)Number and percent of member budgets administered by FMS in accordance with state requirements. N: # of Member budgets administered by FMS that followed requirements; D: # of members participating in self-directed services.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| | | |

| | | |
|---|---|---|
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

For Performance Measure PM 1, DOM will (a) ask MDRS to provide report monthly; and (b) review inter-agency agreement as needed; (c) DOM and MDRS will cease enrollment immediately if expenditures exceed estimates of the waiver.

For PM 2, DOM will (a) ask MDRS for report monthly; and (b) review inter-agency agreement as needed; (c) DOM and MDRS will cease enrollment immediately if expenditures exceed estimates of the waiver.

For PM 3, DOM will (a) ask MDRS to conduct a new LOC evaluation by a qualified staff person within seven days; and (b) collaborate with MDRS to examine if any changes need to be implemented systemically as needed.

For PM 4, DOM will have MDRS to (a) examine the cause within thirty days; (b) conduct the quarterly review

and update the Plan of Care within thirty days; (c) provide staff training within thirty days; (d) refund the payment within thirty days.
For PM 5, DOM will have MDRS to (a) replace individual with a qualified counselor within seven days; and (b) review hiring practices and modify if necessary in thirty days.
For PM 6, DOM will (a) ask MDRS for the missing reports within seven days; and (b) collaborate with MDRS to examine if any changes need to be implemented systemically as needed.
For PM 7, DOM will (a)request the FMS and waiver participant to remove any PCA from providing services who does not meet the provider qualifications immediately, (b) require the FMS to assure PCA meets qualifications prior to providing care, (c) ask FMS to reevaluate the participant's knowledge and reeducate as needed regarding hiring practices in seven days
For PM 8, DOM will (a) request FMS to submit a corrective action plan to correct deficient practices within thrity days, (b) DOM will provide provider training to address deficient practices as needed.
For PM 9, DOM will (a) request that FMS submit a corrective action plan for deficient practice of improper administering budgets within thirty days, (b) provide provider training relevant to deficient practice within thirty days, (c) DOM may sanction the provider agreement with the FMS if deficient practice is repetative as needed.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☑ Aged or Disabled, or Both - General | | | | | |
| | ☑ | Aged | 65 | | ☑ |
| | ☑ | Disabled (Physical) | 16 | 64 | |
| | ☑ | Disabled (Other) | 16 | 64 | |
| ☐ Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☐ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☐ | Autism | | | ☐ |
| | ☐ | Developmental Disability | | | ☐ |
| | ☐ | Intellectual Disability | | | ☐ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

The participant must:
1) Exhibit severe orthopedic and/or neurological impairment that renders the participant dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living.
2) Be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, counselors/case managers, or others involved in their care.
3) Be medically stable. Medical stability is defined as the absence of any of the following: (a) An active, life threatening condition (sepsis, respiratory, or other conditions requiring systematic therapeutic measures); (b) IV drip to control or support blood pressure; (c)intracranial pressure or arterial monitoring.

There is no maximum age limit for this waiver. The minimum age limit is 16 years.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

The electronic waiver application will not allow documentation of any number beyond 64 as an expected value for the age limit of individuals with disabilities. However, the state does not have a maximum age limit for individuals with disabilities in this waiver. Therefore, no age limit transition plan is needed.

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  **The limit specified by the State is** *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - **Other**

    *Specify:*

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

  **The cost limit specified by the State is** *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount:

    **The dollar amount** *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prior to the admission to this waiver, the case management team completes a thorough Long Term Care Preadmission Screening process to determine how the applicant/participant could be best served. The overall assessment of the waiver applicant/participant provides an estimated projection of the total cost for services to determine whether the applicant's/participant's needs can be met in a manner that assures the applicant's/participant's health and welfare. Along with the preadmission screening, the case management team supplies DOM with a Plan of Care (Service Plan) with specific service needs of the applicant/participant. An oversight review by a registered nurse at DOM is conducted to ensure all of the waiver applicant's/participant's needs will be met by the specified services. If a applicant's/participant's needs cannot be met within the capacity of the waiver, it is explained to the applicant/participant along with a Notice of Action for a Fair Hearing. Suggestions are given for other long term care alternatives.

On average, the cost for a waiver applicant/participant must not be above the average estimated cost for nursing home level of care approved by CMS for the current waiver year. DOM must assure the waiver is cost neutral.

If MDRS determines a particular applicant's/participant's care costs are threatening the cost neutrality of the waiver, the operating agency must collaborate with DOM as soon as possible to review the plan of care. If entrance into the waiver is denied the waiver aplicant/ participant will be informed in writing for the denial and provided the opportunity for a fair hearing.

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [x] **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Each additional service requested is thoroughly reviewed by the administrative staff at MDRS and additionally by a Medicaid program nurse.

If the service is deemed appropriate, the medicaid program nurse will approve the request and will notify the staff at MDRS of the approval.

If the additional services requested are determined to exceed the average estimated cost, then the request may be denied per MDRS. The denial must not compromise the quality of care of the individual in any way; if so, an approval may be granted by overriding the denial via management of DOM and/or MDRS.

If an increase in services is denied, the waiver participant will be informed and given the opportunity to request a

fair hearing.

☑ **Other safeguard(s)**

Specify:

DOM and MDRS work collectively to ensure the waiver participant's needs are met. This process includes examining third-party resources, possible transition to another waiver or institutional services.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 3500 |
| **Year 2** | 4000 |
| **Year 3** | 4500 |
| **Year 4** | 5000 |
| **Year 5** | 5500 |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

**Not applicable. The state does not reserve capacity.**

**The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

| Purposes |
|---|
| Reservation of capacity for persons transitioning from Nursing Homes and/or other Home and Community Based Services (HCBS) waivers |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Reservation of capacity for persons transitioning from Nursing Homes and/or other Home and Community Based Services (HCBS) waivers

**Purpose** *(describe):*

MDRS agrees to reserve capacity for each waiver year for individuals transitioning from nursing facilities and other home and community-based services (HCBS) waivers.

If the reserve capacity is not utilized within three (3) months of the end of the waiver year, MDRS reserves the right to reassign the reserve capacity for others awaiting services.

**Describe how the amount of reserved capacity was determined:**

DOM evaluated the number of referrals received for transition from nursing facilities to a community setting for FY 2011. The findings revealed that approximately 25 referrals were received by the HCBS department. These referrals, if appropriate, were transitioned into the community with services of either of the four waivers administered by the LTC Division of Medicaid. It was determined that reserving capacity for 25 IL waiver participants in addition to capacity reserved in other waivers would be sufficient to meet the needs of individuals wishing to transition out of nursing facilities into a Home and Community setting.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 25 |
| Year 2 | 25 |
| Year 3 | 25 |
| Year 4 (renewal only) | 25 |
| Year 5 (renewal only) | 25 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix**

**B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one*:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

MDRS maintains a statewide referral database of individuals who request waiver services through the IL waiver. The statewide database is maintained on date of referral.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one*:

- **100% of the Federal poverty level (FPL)**
- **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

1902 (a) (10) (A) (i) (VII)-Children 100%

1902 (a) (10) (A) (ii) (VIII)-Adoption Assist. Foster Children

1902 (a) (10) (A) (i) (I)-IVE foster children and adoption assistance

1902 (a) (10) (A) (ii) (I)-CWS foster children (reasonable classification of children)

1902(a) (10) (A) (ii) (XVII)-protected foster care adolescents

1634(c) and 1939(a) (2) (D) of the Act-Disabled adult children (ages 19 and over)

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***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

---

- **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

- **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

- [x] **A special income level equal to:**

*Select one*:

- **300% of the SSI Federal Benefit Rate (FBR)**

- **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

  Specify percentage:
- **A dollar amount which is lower than 300%.**

  Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

  *Select one*:

  - **100% of FPL**
  - **% of FPL, which is lower than 100%.**

    Specify percentage amount:
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  *Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - **Use spousal post-eligibility rules under §1924 of the Act.**
    *(Complete Item B-5-b (SSI State) and Item B-5-d)*
  - **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    *(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*
- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

- ○ **The following standard included under the State plan**

  *Select one*:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the State Plan**

    *Specify:*
- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ◉ **The following formula is used to determine the needs allowance:**

  *Specify:*

  The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller Trust.
- ○ **Other**

*Specify:*

**ii. Allowance for the spouse only** (*select one*):

- **Not Applicable (see instructions)**
- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

*Specify:*

**iii. Allowance for the family** (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

*Specify:*

- **Other**

*Specify:*

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 4)

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

**ii. Frequency of services.** The State requires (select one):

- **The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- **Other**

*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The Initial Evaluation is conducted by a case manager/counselor and registered nurse using a Preadmission Screening tool. The case manager/counselor must at minumim have a Bachelors Degree in Rehabilitation counseling, or other related field and one year relevant experience; in addition, the registered nurse must be licensed without restrictions in the state of Mississippi. The case management team conducts the assessment at the time of evaluation, and enters the participant's pertinent data into the PAS. The case manager/counselor does not determine level of care.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A comprehensive preadmission screening process is used to ensure the needs of the applicant/participant are fully captured. The process involves a collection of objective clinical eligibility criteria that is to be applied uniformly regardless of the current or future placement. The process will allow applicants/participants found clinically eligible for long term care to make an informed choice between institutional and community-based services. It will also support discharges from the nursing facility, if the applicant/participant desires to move into the community. Additionally, the level of care is certified by a physician.

Mississippi developed a comprehensive Pre-Admission Screening (PAS) tool in order to ensure that the needs of the applicant are fully captured, regardless of current or future placement. The tool is a collection of objective clinical eligibility criteria that is to be applied uniformly. The process will allow persons found clinically eligible for long term care to make an informed choice between institutional and community-based services. Eligibility for the Independent Living Waiver is determined through the application of the comprehensive PAS instrument encompassing activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, behaviors and medical conditions/services. PAS data is entered into a scoring algorithm to generate a numerical score. The score is compared to a numerical threshold for eligibility, with those at or above the threshold deemed clinically eligible. Applicants/participants scoring below the threshold may qualify for a secondary review by a DOM/LTC clinician before eligibility is denied. Applicant/participants also retain their customary appeal/Fair Hearing rights in accordance with Medicaid policy.

If an applicant/participant is denied waiver services based on failure to meet level of care eligibility, he/she will be

notified of the reason for denial along with information and assistance if needed, to request and arrange for a fair hearing.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The comprehensive preadmission screening process is used in order to ensure that the needs of the applicants/participants are fully captured. The process involves a collection of objective clinical eligibility criteria that is to be applied uniformly regardless of the current or future placement. The process will allow applicants/participants found clinically eligible for nursing facility level of care to make an informed choice between institutional and community-based services. It will also support discharges from the nursing facility, if the applicant/participant desires to move into the community. Additionally, the level of care is certified by a physician.
A scoring algorithm has been designed using an eligibility threshold per DOM policy. Applicants/participants scoring within the threshold will be deemed clinically eligible.

Applicant/participants also retain their customary Fair Hearing/appeal rights in accordance with Medicaid policy.

The case manager/counselor may perform the level of care reevaluation without the Registered Nurse.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**
  *Specify the other schedule:*

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  *Specify the qualifications:*

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

MDRS has district offices throughout the state. Each of these district offices has manual and automated monitoring systems to ensure that re-certifications are completed timely. These procedures are inclusive of:
1. Tickler file;

2. Edits in the computer system; and
3. Component part of case management.
The goal of each office is to renew these in a timely manner so that there will not have to be a lapse in service for the participant. A statewide tickler file and computer edits are also maintained in the state office of MDRS to further ensure timely reevaluations.

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The original participant record is housed at MDRS. The preadmision screen is submitted electronically which produces a copy that is housed in DOM's OmniTrack database. MDRS is required to keep the entire document for the period of time specified under the current federal guidelines.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

**i. Sub-Assurances:**

**a.** ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**1)Number and percent of waiver applicants who receive a Preadmission Screening prior to the receipt of waiver services. Numerator: Number of waiver applicants who receive a Pre-admission Screening prior to the receipt of services; Denominator: Total number of applicants.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**OmniTrack**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative** |

| | | |
|---|---|---|
| | | **Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on*

*the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**2)Number and percent of waiver participants who receive a recertification screening within 365 days. Numerator: number of participants who received a recertification screening within 365 days; Denominator: total number of participants who received a recertification screening.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Omnitrack**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| | |
|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**3)Number and percent of participants certified by a physician in less than 90 days prior to the expiration of the current certification. Numerator: number of participants certified by a physician in less than 90 days; Denominator: total number of participant re-certification.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Omnitrack and MMIS (HCBS certification compared to end date of current lock-in)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe |

| | | |
|---|---|---|
| | | Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**4)Number and percent of participant's initial and recertification preadmission screenings where the criteria are accurately applied. Numerator: number of participants' initial and recert PAS where the criteria are accurately applied; Denominator: total number of initial and recert PAS reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Home visits with specific questions from the PAS that will be used to compare to the criteria applied by the case managers/counselors**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Less than representative sample due to lack of resources. Representativeness met with 1st Level of Care performance measure. |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by

the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

For Performance Measure (PM) 1, DOM will have (a) MDRS obtain correct documentation prior to DOM completing determination letter; (b) MDRS conduct pre-admission screening within fifteen days; (c) MDRS and DOM disenroll the participant immediately (30 day notice to appeal); and (d) DOM will retract payment from the provider within thirty days.

For PM 2, DOM will (a) require MDRS to submit PAS within fifteen days; (b) require MDRS to submit Discharge 105 within seven days; (c) work case as a new case (readmission) within thirty days; and (d) conduct provider training as needed.

For PM 3, DOM will (a) require MDRS to provide provider training within 30 days and (b)require MDRS to close the application and submit a new certification within 30 days.

For PM 4, DOM will (a) hold meetings to review findings quarterly; (b) MDRS and DOM will use a team approach always; (c) DOM and MDRS will determine potential solutions and present to administration, as needed.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of*

*care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The preadmission screening process requires the participant or their legal representative to sign and attest to their choice of placement on an Informed Choice form. During this portion of the preadmission screening process, long term care program options are explained by the counselor and the participants indicate their choice of waiver services or institutional services by evidence of their signature and initials placed by service choice. The Informed Choice section is to match the person's care needs, strengths, and desires with DOM-covered long term care programs, to ensure the participants, and participant's family, is able to make an informed choice from the available DOM-covered options.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The original participant record is housed at MDRS. The PAS tool is to be submitted electronically which produces a copy that is housed in DOM's OmniTrack database. MDRS is required to keep the entire document for the period of time specified under the current federal guidelines.

# Appendix B: Participant Access and Eligibility

## B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The State subscribes to a language line service that provides interpretation services for incoming calls for the waiver participant with limited English proficiency(LEP). The subscribed interpretation service provides access in minutes to persons who interpret from English into as many as 140 languages. Each Medicaid Regional office is set up with an automated access code under the State identification code.

An LEP Policy has been established. All essential staff have received training on the use of the Language Line Service. All necessary steps have been taken to ensure that staff understand the established LEP policy and are capable of carrying it out.

The key to the telephone language interpreter service is to provide meaningful access to benefits and services for LEP persons and to ensure that the language assistance provided results in accurate and effective communication between the Division of Medicaid and participants about the types of services and/or benefits available and about the participant's circumstances.

# Appendix C: Participant Services

## C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service |
|---|---|
| **Statutory Service** | **Case Management** |
| **Statutory Service** | **Personal Care Attendant** |
| **Supports for Participant Direction** | **Financial Management Services** |
| **Other Service** | **Environmental Accessibility Adaptations** |
| **Other Service** | **Specialized medical equipment and supplies** |

| | |
|---|---|
| **Other Service** | **Transition assistance services** |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| **Category 2:** | **Sub-Category 2:** |
| **Category 3:** | **Sub-Category 3:** |
| **Category 4:** | **Sub-Category 4:** |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Case management services will assist waiver applicant/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Case managers/Counselors shall be responsible for ongoing monitoring of the provision of services included in the participant's plan of care.

Case managers/Counselors shall initiate and oversee the process of assessment and reassessment of the participant's level of care and review the plan of care to ensure services specified on the plan of care are appropriate and reflective of the participant's individual needs.

Case Managers/Counselors are responsible for ensuring that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e. infection control, principles of safety, disability

awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs). Case managers/counselors make quarterly home visits to observe whether all services are being provided according to the approved plan of care.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Case Manager/counselor is required to make phone contact at least once monthly and a face to face visit with the participant at least every three months. Case managers are expected to visit more frequently in the event of alleged abuse, neglect or exploitation of waiver participants.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Rehabilitation Counselor/Registered Nurse |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Rehabilitation Counselor/Registered Nurse

**Provider Qualifications**

**License** *(specify):*

Nurse must have a current and active unencumbered registered nurse license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license, and at least one year of experience with the aged and/or individuals with disabilities. The nurse must not have a history of a criminal offense which precludes him/her from working with the vulnerable population. The nurse must not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General exclusion list.

**Certificate** *(specify):*

NA

**Other Standard** *(specify):*

The Rehabilitation Counselor must possess at minimum of a Bachelor's degree in Rehabilitation Counseling or other related field, and one year of experience working with individuals with disabilities. The rehab counselor must be free of a history of a criminal offense which would preclude him/her from working with a vulnerable population. The rehab counselor's name must not appear on the Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) exclusion list.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Mississippi Department of Rehabilitation Services (MDRS) validates qualifications of the RN and rehab counselor. MDRS subscribes with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken occurring against nurse employees.

**Frequency of Verification:**

Ongoing and annually.

## C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Personal Care Attendant

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| **Category 2:** | **Sub-Category 2:** |
| **Category 3:** | **Sub-Category 3:** |
| **Category 4:** | **Sub-Category 4:** |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Personal Care Services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. Personal Care Service may include:

a) support for activities of daily living such as but not limited to, bathing (sponge, tub), personal grooming and dressing, personal hygiene, toileting, transferring, and assisting with ambulation.

b) assistance with housekeeping that is directly related to the participant's disability and which is necessary for the health and well-being of the participant such as, but not limited to, changing bed linens, straightening area used by the participant, doing the personal laundry of the participant, preparation of meals for the participant, cleaning the participant’s equipment such as wheelchairs or walkers rather than the participant's family.

c) food shopping, meal preparation and assistance with eating, but does not include the cost of the meals themselves;

d) support for community participation by accompanying and assisting the participant as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities, but does not include the price of the activities themselves.

Personal Care Services are non-medical, hands-on care of both a supportive and health related nature. The

provision of Personal Care Services is recorded on the plan of care, and is not purely diversional in nature. Attendant care services may be furnished by family members provided they are not the parent (or step-parent) of a minor child or their spouse; only qualified family members who are not legally responsible for the waiver participant may be employed as the personal care attendant. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the IL counselor/registered nurse. There must be adequate justification for the relative to function as the attendant, e.g., lack of other qualified attendants in remote areas.

Participant Directed personal care service recognizes the waiver participant's responsibility as the employer of record. Waiver participatns will provide budgetary and employer functions for related to the PCA service. The waiver particpant will have the authority to negotiate salaries and benefits regarding personal care services.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The Mississippi State Plan includes personal care services as a 1905(a) service available to EPSDT recipients under the age of 21, if medically necessary, and not addressed elsewhere in the State Plan. However, the state ensures that personal care services are not duplicated by this waiver for waiver participants under the age of 21. The case manager identifies all comparable benefits for participants of all services. If a needed service is available through the Medicaid State Plan, Medicare, or private insurance, it is provided as a non-waivered service. DOM reviews 100% of all Plans of Care at initial application and each annual recertification. MDRS conducts quarterly reviews of all Plans of Care, Secondary reviews of all Plans of Care by in-house medical staff, and annual programmatic audits by Program Evaluation. DOM conducts annual compliance reviews and on-site visits to ensure appropriate billing. Additionally, service restrictions are imposed with the use of the Lock-in. A review of claims history can be conducted to determine if personal care services are being provided and covered through the State Plan.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Personal Care Attendant |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Personal Care Attendant**

**Provider Category:**
Individual

**Provider Type:**
Personal Care Attendant

**Provider Qualifications**

**License** *(specify):*
N/A

**Certificate** *(specify):*
N/A

**Other Standard** *(specify):*
A personal care provider must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant program. The training, to be conducted by the participant/caregiver and the counselor/registered nurse, or an agency permitted by law to train nurse aides, shall include the purpose and philosophy of self-directed services by the disabled, disability

awareness, employee-employer relationships and the need for respect for the participant's privacy and property. Instructions will cover the basic elements of body functions, infection control procedures, maintaining a clean and safe environment, appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance. A section on housekeeping instructions will cover meal preparation and menus that provide a balanced, nutritional diet. The educational program will be personalized with participation of the participant to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants will not be provided under the waiver.

The individual must demonstrate competency to perform each activity of daily living task to the participant and counselor/registered nurse prior to rendering any waivered services. In addition to the technical skills required, the personal care provider must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the participant and counselor/registered nurse to be adequate in fulfilling the responsibilities of personal care.

An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the classroom training requirements. Competency certification for these personal care providers by the participant and counselor/registered nurse is required.

A personal care attendant that has satisfactorily provided personal care attendant services for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the participant and the Counselor/Registered Nurse, shall be deemed to meet the training requirement.

Personal care services may be furnished by family members provided they are not the parent (or step-parent) of a minor child or their spouse; only qualified family members who are not legally responsible for the waiver participant may be employed as the personal care attendant. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the counselor/registered nurse. There must be adequate justification for the relative to function as the attendant, e.g., lack of other qualified attendants in remote areas.

Minimum Requirements:

-must be at least 18 years of age;

-must be a high school graduate, have a GED or demonstrates the ability to read and write adequately to complete required forms and reports of visits;

-must be able to follow verbal and written instructions;

-must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to participant;

-must be certified as meeting the training and competence requirement by the participant and the Counselor/Registered Nurse;

-must be able to communicate effectively and carry out directions.

-must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors which include, but are not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.
-must recieve training in the areas of the Vulnerable Person's Act, care giver boundaries and dealing with difficult patients upon hire and annually thereafter,

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Mississippi Department of Rehabilitation Services verifies the competency for all personal care providers.
**Frequency of Verification:**
AS NEEDED

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
**Support for Participant Direction:**
Financial Management Services
**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| Category 2: | Sub-Category 2: |
| Category 3: | Sub-Category 3: |
| Category 4: | Sub-Category 4: |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
FMS is a support service to assisst the waiver participant who chooses the Participant-Directed Pesonal Care Service. Participant-Directed personal care service recognizes the waiver participant as the employer of record. The waiver participant will provide budgetary and employer functions. The waiver participant will have the ability to negotiate salaries and benefits with the personal care attendants. The FMS agent assist the waiver participant with employer and budget authority by ensuring that Federal, State and local employment taxes and labor and worker's compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner as related to the personal care attendant. The FMS ensures that the necessary employer related duties and tasks, including payroll, are carried out.

The service ensures initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

The FMS service provider also:
* Serves as the participant's employer agent which is the IRS designation of the entity responsible for IRS-related responsibilities on behalf of the participant,
* Provides assistance determining staff wages and benefits,
* Provides assistance in hiring by verifying employees' citizenship status, conducts criminal background checks, checks the Mississippi Nurse Aide abuse Registry and the Office of Inspector General (OIG) exclusion lists,
* Verifies and maintains documentation of employee qualifications, citizenship status, and documentation of services delivered,
* Provides information on recruiting, hiring and firing staff including identifying the need for special skills and determining duties and schedule,
* Collects timesheets, processes timesheets of employees, processes payroll and payables and makes withholdings for, and payment of, applicable and federal, State and local employment related taxes,
* Provides quarterly written reports to the waiver participant of all expenditures and the status of the waiver participant's budget
* Maintains a separate account for each waiver participant

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | FMS agency with an approved Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Supports for Participant Direction**
**Service Name: Financial Management Services**

**Provider Category:**
Agency
**Provider Type:**
FMS agency with an approved Medicaid provider agreement
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
The provider will:

*make services available only to those persons deemed eligible and referred by MDRS
*develops and maintains policies and procedures for the delivery of Financial Management Services FMS
*establish contact with the participant within five working days of the referral from MDRS
*conduct a face-to-face visit to initiate the FMS process within five working days of establishing contact with the participant
*conduct at least one face-to-face meeting annually with each participant to review and update the overall function of the FMS
*ensure Division of Medicaid (DOM) access to the participant's case files
*employ staff members with knowledge, experience and abilities to sufficiently carry out the FMS component of service

FMS providers hold Medicaid provider agreements with the DOM. The types of entities that will provide FMS will be through vendor organizations via a Medicaid Provider agreement. Preferably, the FMS should have a minimum of five (5) years of billing and payroll experience relevant to participant-directed medical care. The FMS preferably shall have a working knowledge of disability etiquette, psychology, and social aspects of disability, vulnerable perons act including reporting requirements , HCBS waivers (especially the plans of care) and W-2 employee tax reporting requirements. However if an FMS lacks a working knowledge of disability etiquette, psychology and social aspects of disability, vulnerable person's act and home and community based waivers, training will be provided to ensure the FMS has a solid foundation for working with individuals with disabilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOM will verify qualifications of a FMS agent.

**Frequency of Verification:**
FMS are monitored annually by DOM and more frequently if the need is indicated or if there is a complaint filed against the FMS.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Environmental Accessibility Adaptations

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Those physical adaptations to the home, required by the participant's plan of care, which are necessary to ensure the health, welfare, and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Environmental Accessibility Adaptations |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Accessibility Adaptations**

**Provider Category:**
Individual
**Provider Type:**
Environmental Accessibility Adaptations
**Provider Qualifications**
**License** *(specify):*
N/A
**Certificate** *(specify):*
N/A
**Other Standard** *(specify):*
General Service Standards:
1. All providers must meet any state or local requirements for licensure or certification, where applicable (such as building contractors, plumbers, electricians or engineers).

2. All modifications, improvements or repairs must be made in accordance with local and state housing and building codes.
3. Quality of work
a. all work should be done in a fashion that exhibits good craftsmanship.
b. all materials, equipment, and supplies should be installed clean, and in accordance with manufacturer's instructions.
c. contractor is responsible for all permits that are required by local government bodies.
d. all non-salvaged supplies and/or materials should be new and of best quality, without defects.
e. at completion of project, contractor will be responsible for removal of all excess materials and trash, leaving the site clear of debris.
f. all work should be accomplished in compliance with applicable codes, ordinances, regulations and laws.
g. the specifications and drawings shall not be modified without a written change order from the case manager.
h. no barriers shall be created by the modification and/or construction process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Mississippi Department of Rehabilitation Services

**Frequency of Verification:**
As Needed

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Specialized medical equipment and supplies

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| **Category 2:** | **Sub-Category 2:** |
| **Category 3:** | **Sub-Category 3:** |
| **Category 4:** | **Sub-Category 4:** |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Specialized medical equipment and supplies to include devices, controls, or appliances which enable the participant to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These items must be specified on the plan of care.
This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items. Also covered are durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be those items which are deemed as medically necessary for the individual client. Medicaid waiver funds are to be utilized as a payor of last resort. Request for payment must be made to other payors (i.e. Medicare, State plan, and private insurance) prior to submission of billing request to utilize waiver funds. All items shall meet applicable standards of manufacture, design and installation.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Each request for specialized medical equipment is evaluated by the Rehabilitation Counselor or Division of Medicaid (DOM) staff to determine if the equipment requested could benefit from an Assistive Technology (AT) evaluation and recommendation.
If the preadmission screening determines that supplies and case management service are the only services needed by an applicant, the applicant would not meet waiver eligibility.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Specialty Medical |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized medical equipment and supplies**

**Provider Category:**
Agency
**Provider Type:**
Specialty Medical
**Provider Qualifications**
**License** *(specify):*
N/A
**Certificate** *(specify):*
N/A
**Other Standard** *(specify):*
Providers of specialized medical equipment and supplies under this home and community –based services waiver shall meet the following minimum qualifications:

A)General Business Standards: a permanent local address & phone number, State of MS sales tax number, Federal I.D. number or social security number, Liability insurance

B)General Service Standards: Manufacturer's guarantee or warranty must be honored as published,

provide repair capability for products

Providers should meet the following additional standards for custom in-house seating systems, powered mobility, three wheel scooters, and high-tech systems:

Provide documented proof of attendance of training with seating & positioning, maintain a current list of power chair manufacturers represented, have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer, maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above, must be able to deliver and assemble all equipment to be ready for final adjustment and fitting, have and present at purchase all necessary manuals, warranties, and provide written warranties, and must be able to provide instruction in proper use and care of equipment. Must be capable to provide training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price; must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Mississippi Department of Rehabilitation Services

**Frequency of Verification:**
as needed

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Transition assistance services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Transition Assistance Services are services provided to a Mississippi Medicaid eligible nursing facility resident to assist in transitioning from the nursing facility into the Independent Living Waiver program. Transition assistance is a one-time initial expense required for setting up a household. The expenses must be included in the approved plan of care.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Transition assistance services are capped at $800.00 one-time initial expense per lifetime.

Transition Assistance Services include:
1) Security deposits that are required to obtain a lease on an apartment or home
2) Essential furnishings and moving expense required to occupy and use a community domicile
3) Set up fees or deposits for utility or service access (i.e. telephone, electricity, heating)
4) Health and safety assurances, such as pest eradication, allergen control, or one time cleaning prior to occupancy
(Essential items for an individual to establish his/her basic living arrangement includes such items as a bed, table, chairs, window blinds, eating utensils, and food preparation items.) Diversional or recreational items such as televisions, cable TV access or VCR/DVD's are not considered furnishings.

Need for this service: All items and services covered must be essential to:
1) Ensure that the participant is able to transition from the current nursing facility
2) Remove an identified barrier or risk to the success of the transition to a more independent living situation.

To be eligible:
1) Participant must be a current nursing facility (NF) resident whose NF services are being paid by Medicaid
2) Not have another source to fund or attain the items or support
3) Transitioning from a living arrangement where these items were provided
4) Transitioning to a residence where these items are not normally furnished

The transition service must occur within 90 days of the discharge, but must be completed by the day the participant relocated from the institution.

Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Case Management |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Transition assistance services**

**Provider Category:**

Agency

**Provider Type:**

Case Management

**Provider Qualifications**

**License** *(specify):*

Nurse must be licensed to practice in the state of Mississippi, and have at least one year of experience.

**Certificate** *(specify):*

NA

**Other Standard** *(specify):*

The Rehabilitation Counselor must possess a minimum of a Bachelor's degree in Rehabilitation Counseling or a related field, and one year of experience.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

MS Department of Rehabilitation Services

**Frequency of Verification:**

At least annually

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- **As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- **No. Criminal history and/or background investigations are not required.**
- **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be

conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Section 37-33-157 of the Mississippi Code of 1972, annotated, as amended, MDRS is authorized to fingerprint and perform criminal background investigations on personal care attendants.
MDRS is authorized to use the results of the investigations for the purpose of employment decisions and/or actions and service provision to consumers of the department's services.
Any person who has been convicted of a felony or certain misdemeanors in this state or any other jurisdiction is not eligible to be employed as a personal care attendant.
Personal care attendants must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors including , but not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

This background check allows the agency to check things such as credit history, criminal records, work history, and driving record.
If a waiver participant chooses the participant directed option for managing personal care attendants, the FMS will be responsible for obtaining the criminal background check.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

MDRS is responsible for verifying that any potential personal care attendant providers are not on the Mississippi Nurse Aide Abuse Registry which is housed at the Mississippi State Department of Health within the Division of Licensure and Certification.

The FMS provider will verify that the personal care attendants employed by the waiver participant have not been placed on the Mississippi Nurse Aide Abuse Registry.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a

spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Personal care services may be furnished by members of the participant's family provided that they are not legally responsible for the waiver participant. Therefore, payment will not be made for services furnished by the parent (step-parent) of a minor child or the participant's spouse. Payment is made to family members only in return for specific services rendered. Family members who provide personal care services must meet the same standards as providers who are unrelated to the participant. The family members may be aunts, uncles, grandparents, siblings or parents of adult children. There must be adequate justification for the relative to function as the Personal Care Attendant, e.g., lack of qualified attendants in remote areas.

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

When DOM is contacted, referrals are made to MDRS as the operator and billing provider for this service. Service vendors are evaluated based on rehabilitation service requirements. MDRS attends job fairs, trade shows, and works with the Employment Security Commission on a regular basis to assure that an adequate pool of vendors are available for all services.

DOM will select the Mississippi FMS contract thru an application process. These procedures are based on reasonable competition, standardized criteria and objective evaluation of submitted proposals. The evaluation process consists of the appointment of an evaluation committee and completion of the evaluation form.

The evaluation form is the assessment tool that will be used by the evaluation committee to evaluate each submitted proposal. The evaluation committee will review the provider's response to each requirement in order to determine if the provider sufficiently addresses the requirement and that the provider has developed a specific approach to meeting each requirement.

A point system will be used to rate each of the proposals. The maximum number of points that may be received by each provider is outlined below:

Maximum Points Per Requirement

1. Statement of Understanding 20
2. Approach 50
3. Organizational Profile 20
4. Financial Information 10

Total Points 100

Upon completion of the evaluation, providers will be ranked based on the number of points received during the evaluation.
All proposals that meet the qualifications for submission will be reviewed in accordance with the system identified above. Those proposal in which the approach is consistent with the intent and design of the waiver program and whose proposed cost are within the DOM budget neutrality projection will be ranked by the DOM review committee. Depending on the number and quality of proposals, DOM will select, at a minimum, two proposals. In order to quantify quality for the purpose of provider enrollment, a minimum threshold score of 80/100 has been established. Any provider who meets the threshold or 80 will be enrolled as a provider.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**1)Number&percent of new RN case manager applications for which the RN obtained licensure in accordance with waiver qualifications prior to service provision. Numerator: Number of new RN case manager applications for which the RN obtained appropriate licensure in accordance with waiver qualifications prior to service provision.Denominator: Total number of new RN case manager applications**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AACE (Accessible Automated Case Environment)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** | ☐ **Annually** |

| | |
|---|---|
| Specify: | |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**2)Number and percent of enrolled RN case managers who continue to meet applicable licensure following initial enrollment. Numerator: Number of enrolled RN case managers continue to meet applicable licensure following initial enrollment. Denominator: Total number of enrolled RN case managers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Compliance Audit**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data** | **Frequency of data aggregation and** |
|---|---|

| **aggregation and analysis** *(check each that applies):* | **analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**3)Number and percent of enrolled non-licensed/non-certified providers, by provider type, who met initial waiver provider qualifications. Numerator: Number of enrolled non-licensed/non-certified providers, by provider type, who met initial waiver provider qualifications. Denominator: Total number of non-licensed/non-certified provider applications**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AACE ( Accessible Automated Case Environment)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**4)Number and percent of enrolled non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications. Numerator: Number of enrolled non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications. Denominator: Total number of enrolled non-licensed/non-certified providers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AACE (Automated Accessible Case Environment)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: Every 24 months | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**5)Number and percent of enrolled providers, by provider type, meeting provider training requirements. Numerator: Number of enrolled providers, by provider type, meeting provider training requirements. Denominator: Total number of enrolled providers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AACE ( Accessible Automated Case Environment)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |

| | |
|---|---|
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
For Performance Measure (PM) 1, DOM will require MDRS to pend the application for required licensure documentation immediately.
For PM 2, (a)DOM will require MDRS to remove employee from providing care to waiver participants due to not meeting licensure requirements immediately; (b) MDRS will take necessary measures to assure the participant continues to receive services immediately.
For PM 3, DOM will require MDRS to cease providing care to the waiver participant by the waiver employee due to not meeting non-certified provider requirements immediately.
For PM 4, DOM will require MDRS to remove the non-licensed employee immediately from duties of providing care to waiver participants until such time the employee meets the standards.
For PM 5, DOM will (a) require MDRS to remove the PCA from providing care to waiver participants immediately;(b) ask MDRS to apply applicable measures to ensure the provider is trained prior to resuming care; (c) expect MDRS to apply applicable disciplinary action if warranted in accordance with their policies and procedures as needed.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ( ) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- (●) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☑ **Other Type of Limit.** The State employs another type of limit.

*Describe the limit and furnish the information specified above.*

The average cost for a waiver applicant/participant must not be above the average estimated cost for nursing home level of care approved by The Centers of Medicaid and Medicare Services for the current waiver year. DOM must assure the waiver remains cost neutral. If the total projected annual cost of all services requested exceeds the most recent annual nursing home bed cost, then the request is denied and returned for reconsideration. The participant is explained the cost neutrality provisions. At that point, some negotiation may occur regarding the amount of services requested under this waiver, whether or not another waiver may have a package of services which can more efficiently meet the needs of the applicant/participant, or whether nursing home is the most appropriate setting based on the amount and complexity of services required. If the annual cost to serve a person in this waiver exceeds the annual nursing home costs, the cost neutrality requirement is jeopardized.
There is reference in Appendix B of this waiver renewal application to provisions for participant safeguards. Following these safeguard procedures, it is possible for an individual to exceed the cost neutrality limit, but the possibility of such occurrences is mitigated by active case management. These requests are considered on an individual basis considering each on its own merits. Related decisions are appealable and covered as addressed in Appendix F of this waiver renewal application.

If a waiver applicant is denied services, the waiver participant will be given a notice of action and the opportunity for a fair hearing.

# Appendix C: Participant Services

## C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

# Appendix D: Participant-Centered Planning and Service Delivery

## D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**
Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☑ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

☐ **Social Worker.**

*Specify qualifications:*

☐ **Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The plan of care also known as the service plan is the fundamental tool by which the State ensures the health and welfare of participants in the Independent Living Waiver. The State's process for developing a participant's plan of care requires the plan to be based on a comprehensive preadmission screening process. Plan of care development is conducted with the waiver participant's desires, preferences and needs in mind. The case manager/counselor engages the participant and other interested parties as requested by the participant in developing the care plan that best meets the needs of the participant. Plans of care are approved by a Medicaid Program Nurse prior to services being implemented.

The waiver requires quarterly face-to-face reviews be conducted by the case manager to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. The rehabilitation counselor is also required to make monthly contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required.

Adherence to Freedom of Choice from all qualified providers is assured by ongoing monitoring by operating agency and DOM. The plan of care, including assessment of risk, services, frequency and duration and informing participants of their rights are monitored by the Medicaid agency. This monitoring includes on site audit activity, records reviews (DOM reviews and approves annual recertification of waiver participants), participant phone calls, etc. Each annual site review will include face-to- face interviews of a representative sample of the site caseload, garnering direct feedback from participants and their caregivers.

The State assures measures are in place to ensure conflict-free services. The waiver participants are given a choice of personal care attendants, as well as choice of case managers. The waiver participants will be given the choice to choose between the traditional(participant/co-employer) personal care services and the participant directed(participant/employer of record) personal care services. The MDRS staff are state service employees who neither benefit from nor are held to numbers and quotas. Staff are evaluated solely on quality of work and compliance with rules, policies, and regulations. MDRS is a State Agency that receives funding through the Legislative appropriation process rather than profit from sales/service.

Development of the plan of care includes developing an emergency preparedness plan for all waiver participants.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

After the applicant has made an Informed Choice, understands the criteria for the Independent Living Waiver, and meets clinical eligibility, as determined by the preadmission screening process, the development of the plan of care is initiated. The case manager engages the waiver participant, care givers and other interested parties as requested by the waiver participant in the development of the plan of care. The plan of care development includes discussing all options, desires, personal goals, emergency preparedness needs, and other specific needs of the participant, and how those needs can be best met.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The preadmission screening process is used in order to ensure that the needs of the applicant/participant are fully captured. The process involves an assessment of objective clinical eligibility criteria that is applied uniformly regardless of the current or future placement. The process will allow persons found clinically eligible for long term care to make an informed choice between institutional care and community-based services and between/among waiver services and providers. It will also support nursing facility discharge, if the person desires to transition into the community. Additionally, the level of care is certified by a physician.

After the participant has made an Informed Choice, understands the criteria for the Independent Living Waiver, and meets clinical eligibility, as determined by the preadmission screening process, the development of the plan of care is initiated. The participant is given a description of the services provided by the waiver along with any specific qualifications that apply to each service. An individual assessment is completed of the participant’s home environment to determine the need for any home modifications and/or specialized medical equipment. The case management team (rehab counselor and/or registered nurse) engages the waiver participant, care givers and other interested parties as requested by the waiver participant in the development of the plan of care. The development includes addressing all service options, desires, personal goals, emergency preparedness needs, and other specific needs of the participant, and how those needs can be best met. The POC is developed at the time of the PAS and updated annually.

If changes in the individual’s circumstances and needs are identified, the plan of care may be updated to meet the needs of the individual. The preadmission screening is utilized for admission to the waiver and annual recertification. MDRS is responsible for implementing plan of care. DOM and MDRS are jointly responsible for monitoring the plan of care. MDRS is responsible for coordination of waiver services, State Plan services, services provided through other funding sources and service agencies.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Adherence of Freedom of Choice is required of all qualified providers. Participant involvement and choice, in all aspects of the waiver program and in service planning, is an integral part of identifying and mitigating risks. The case management team must assist the individual and provide them with sufficient information and assistance in order to make an informed choice regarding choice of services and supports, always taking into account risks that may be involved for that individual. The waiver participant and informal caregivers/supports assist in developing strategies and complying with strategies to help mitigate risk and ensure health and safety. This is assured by ongoing monitoring by the operating agency and Division of Medicaid. Service plan is monitored continuously by the operating agency and the Medicaid agency. Monthly and quarterly actions are required to review/assess participant service needs, with a new plan developed every twelve months. The Medicaid agency utilizes a preadmission screening (PAS) process for annual eligibility, admission, and recertification for waiver participation. Beginning at the initial assessment and service planning process, the presence and effect of risk factors must be determined. The assessment is specifically designed to assess and document risks an individual may possess. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. All risk factors identified must be addressed in the plan of care. Risk factors considered are documented abuse/neglect/exploitation, socially inappropriate behavior, communication, nutrition concerns, environmental security and safety, falls, orientation, emotional/mental functioning, and lack of informal support. The case management team must also determine whether a medical condition is present that requires specific intervention to prevent a decline in health and safety.

The types of backup arrangements that are used include the waiver participant designating alternate care providers in the event that the person of their choice is unable to provide care. The participant and caregiver identify family members who are able to provide services in the event of an emergency. The operating agency and the waiver participant also maintains a list of qualified local community providers from which the participant can choose if the participant's choice is not available. During a community disaster or emergency the operating agency case manager notifies the local first response team (i.e. the American Red Cross) of persons with special needs who may require special attention. Back up plans are developed by the operating agency case manager in partnership with the waiver participant and their family/caregiver upon admission. The Counselor evaluates the appropriateness and adequacy of both waiver and non-waiver services at least monthly by phone contact with the client and at a minimum quarterly face-to-face visits with the client. As situations warrant, more frequent face-to-face visits may be made. At each contact/visit, the Counselor is required to document and monitor the delivery of services, as well as, document the individual's health and welfare.

Development of the plan of care includes developing an emergency preparedness plan for all waiver participants.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants in the Independent Living (IL) Waiver are allowed to select the personal care attendant of their choice. The participant is given two (2) options for delivery of personal care service. If a participant knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements to become a personal care attendant as set forth in the IL Waiver, that individual is allowed to provide the direct care for that waiver participant.

If a participant knows a particular individual with whom they are comfortable providing their personal care and that individual does not meet the requirements as set forth in the IL Waiver, that individual is trained and once qualified is allowed to provide the direct care for that waiver participant. If an individual waiver participant does not have a specific direct care worker, they can select from a list of available, eligible, qualified direct care workers to provide their personal care assistance. Personal care services may be provided by members of the participants's family provided that they are not legally responsible for the participant. Therefore, the parent (step-parent) of a minor child and the participant's spouse are not allowed to provide personal care services. The executor of the participant's estate and/or person with durable/medical power of attorney is not allowed to provide personal care services.

Waiver participants are provided information about other provider types in accordance with their identified needs, desires and goals noted on the plan of care. The case manager provides the participant with a list of trained, competent and willing providers so the participant may request the provider of choice.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

After the participant has made an informed choice, understands the criteria for the Independent Living (IL) Waiver, and meets clinical eligibility, as determined by the preadmission screening process, the screen along with the plan of care which includes all of the service needs, personal goals and preferences of the applicant, will be submitted electronically to DOM.

A registered nurse at DOM will review the preadmission screening and the plan of care and notify Mississippi Department of Rehabilitation Services in a timely manner of the approval/disapproval of services requested. If additional information is needed by DOM prior to making a determination on 'Added Service' request, the service will be put on pending status until additional information is obtained.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [x] **Medicaid agency**
- [x] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

MDRS is responsible for implementation of the plan of care. DOM and MDRS are jointly responsible for monitoring the plan of care and the health and welfare of the participants. DOM, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place to assure plan of care implementation.

Plans of care are evaluated by a Medicaid program nurse prior to services being implemented. The waiver requires quarterly face-to-face reviews be conducted by the case manager to determine the utilization and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability, needs, preferences and goals. The rehabilitation counselor makes monthly contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required.
If changes in the participant's circumstances and needs are identified, the plan of care may be updated to meet the participant's needs.

MDRS is responsible for coordination of waiver services, State Plan services, services provided through other funding sources and service agencies.

Monitoring for the implementation of the plan of care includes on site review activity, record reviews (DOM reviews and approves annual recertification of waiver participants), participant phone calls to the Medicaid agency, etc. On site reviews include face to face interviews of a representative sample of the site caseload, garnering direct feedback from participants and their caregivers. The MDRS case manager documents personal contact with the waiver participant on a monthly basis to receive feedback and assess the sufficiency and effectiveness of the service plan. The record is reviewed by the Medicaid agency for documentation; and the services are confirmed by the face to face interview with the representative sample waiver participants.

**b. Monitoring Safeguards.** *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

MDRS case managers/counselors are required to provide each waiver participant with written information regarding their rights as a waiver participant along with information regarding the Mississippi Vulnerable Persons Act. Case managers provide the waiver participants with the information and phone numbers of when and who to call if abuse, neglect or exploitation is alleged. Case managers reiterate this information at least annually and more often if needed.

The responsibility of the rehabilitation counselor is to make contact with the participants at least monthly by phone. The participant is given the counselor's name and contact phone number, and the participant can contact the counselor to inquire about any service changes needed to his/her Plan of Care.

As part of DOM's on-going quality assurance monitoring, the State reviews plans of care and individual preadmission screenings to ensure that all services are provided in accordance with the approved plan of care, participants are involved in the care planning process, and activities provided meet service definitions of the approved waiver. The DOM also monitors the delivery of the plan of care by reviewing the participant's clinical record during on site provider compliance reviews conducted at least annually, and during technical assistance provider site visits. The annual review allows for DOM to ensure that the waiver participants are provided with information regarding the Mississippi Vulnerable Persons Act and waiver participant's rights.

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**1)Number and percent of participants whose plans of care address their needs, including health and safety risk factors, based on the preadmissions screening or recertification. Numerator: Number of participants who have plans of care that address their needs including health and safety risk factors.. Denominator: Total number of participants' plans of care.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Omnitrack**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☐ Operating Agency | ☑ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**Performance Measure:**
**2)Number and percent of participants whose plans of care address their personal goals. Numerator: Number of participants who have plans of care that address their personal goals. Denominator: Total number of participants' plan of care reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Omnitrack**

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach *(check each that applies):* |
|---|---|---|
| ☑ State Medicaid Agency | ☐ Weekly | ☑ 100% Review |
| ☐ Operating Agency | ☐ Monthly | ☐ Less than 100% Review |
| ☐ Sub-State Entity | ☐ Quarterly | ☐ Representative Sample<br>Confidence Interval = |
| ☐ Other<br>Specify: | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☑ Continuously and Ongoing | ☐ Other<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**3)Number and percent of participants' plans of care where the individual's signature indicates involvement in the POC development. Numerator: Number of participants' plans of care with signature indicating involvement in POC development. Denominator: Total number of participants' POC reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Omnitrack**

| | | |
|---|---|---|
| | | |

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**

**4)Number and percent of participants' plans of care whose quarterly updates are performed according to the waiver application. Numerator: Number of participants' plans of care whose quarterly updates are performed according to the waiver application. Denominator: Total number of participants' plans of care.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Compliance audit**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = +/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| |
|---|
| ☐ **Continuously and Ongoing** |
| ☐ **Other**<br>Specify: |

**c.** ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**5)Number and percent of participants' plans of care that are updated annually.**
**Numerator: Number of participants' plans of care that are updated annually.**
**Denominator: Total number of participants' plans of care.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Omnitrack**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**6)Number and percent of participants' plans of care that are revised when individuals' needs change. Numerator: Number of participants' plans of care that are revised when needs change. Denominator: Total number of participants' plans of care reviewed with a change in need.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:
**Review by QA nurses**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| | | |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**7)Number and percent of participants who received services in accordance with the service plan in the type, scope, amount, duration, and frequency. Numerator: Number of participants who received services in accordance with the service plan in the type, scope, amount, duration, and frequency. Denominator: Total number of participants' plans of care reviewed.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:
**QA nurse review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| | |
|---|---|
| ☐ **Continuously and Ongoing** | |
| ☐ **Other** Specify: | |

**e.** ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**8)Number and percent of participants' informed choice forms with signature indicating choice between institutional care and the waiver. Numerator: Number of participants' informed choice forms with signature indicating choice between institutional care and the waiver. Denominator: Total number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Omnitrack**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and** | ☐ **Other** |

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**9)Number and percent of participants' freedom of choice forms indicating choice of providers. Numerator: Number of participants' freedom of choice forms indicating choice of providers. Denominator: Total number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Compliance Review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |

| | | |
|---|---|---|
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

For Performance Measure (PM) 1, Division of Medicaid (DOM) will within three to five days of receipt of notification (a) approve plan of care following case manager clarification; (b) approve plan of care following correction by case manager; (c) approve plan of care following change of services by case manager; and (d) provide case manager training by letter

For PM 2, DOM will within three to five days of receipt of notification (a) approve plan of care following case manager clarification; (b) approve plan of care following correction by case manager; (c) approve plan of care

following change of services by case manager; and (d) provide case manager training by letter.
For PM 3, DOM will (a) evaluate all cases for proof of participant participation in the plan of care prior to approving the cases; and (b) provide case manager training as needed.
For PM 4, DOM will (a) require MDRS to complete quarterly update; (b) require MDRS to submit a corrective action plan within thirty days; (c) require MDRS to refund payment within thirty days; and (d) provide case manager training annually.
For PM 5, DOM will (a) continue utilizing 364 day enrollment period for each plan of care; (b) contact provider to determine the cause if the certification lapsed; and (c) provide case manager training annually.
For PM 6, DOM will (a) require plan of care to be updated to address individual's needs by MDRS within seven days upon notification of changes in individual's needs; and (b) provide case manager training annually.
For PM 7, DOM will (a) intervene within seven days to have services delivered or change the plan of care to meet the individual's needs; (b) determine within seven days the cause for services not being delivered; and (c) provide case manager training annually.
For PM 8, DOM will (a) require the case manager to obtain the completed Informed Choice form within seven days; and (b) provide case manager training annually.
For PM 9, DOM will (a) require the case manager to obtain the completed Freedom of Choice form within seven days; and (b) provide case manager training annually.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>as needed |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the

Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver engages the waiver participants to make choices in regards to participant needs, preferences and desires with all aspects of the services provided.

Once a waiver applicant has been determined eligible for waiver services they have the choice of 2 options for personal care service:
1)Participant-Directed personal care service allows the participant to exercise employer and budgetary authority for participants for the personal care service. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a Financial Management Service (FMS) agent to assist with employer and budgetary functions.The waiver participant will have the ability to negotiate salaries and benefits with the personal care attendants while the FMS manages the time sheets, criminal background checks and other employment issues

2)The traditional personal care service, otherwise known as the Co-Participant personal care service, remains a viable choice for those waiver participants who do not desire to be become the employer of record with budgetary control. The Co-Participant choice for personal care service recognizes Mississippi Department of Rehabilitation Services as the employer of record but allows the participant to recruit, hire and terminate employment of personal care attendants. The Co-Participant personal care service does not allow the participant to exercise budgetary authority (excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance).

The FMS is a new support service for the Participant-Directed personal care service option providing assistance to the waiver participant with management of the personal care attendant budget and employer duties as associated with the participant being the employer of record. The FMS will submit claims for attendant services to DOM for payment and is responsible assisting the participant with incuding, but not limited to, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance. This choice provides more autonomy and independence for the waiver participant.

With all other services other than Personal Care Service, the participant is given detailed information about the providers and the participant has the opportunity and is encouraged to choose the provider they feel most comfortable with and who can best meet their needs.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

- **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

The individual may live with several other persons in a private residence, apartment.

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Applicants, participants and other interested parties expressing an interest in the IL are provided information of the options of participant-directed personal care services. MDRS and DOM waiver staff are trained to provide this information upon referral, initial application intake, and ongoing while the participant is enrolled in the waiver. Information is provided to each applicant to assure informed decision making is based on an understanding of the

participant directed service delivery method of choice. Information is presented to the participant by the MDRS case manager which includes: overview of Co-Participant Directed personal care service and the Participant-Directed personal care service choices, a listing of liabilities and benefits of participating in either choice; self-assessment for participation in each option; a listing of required minimum qualifications of personal care attendant providers; and a listing of employee/employer relationships that prohibit employment. The case manager also outlines the roles and responsibilities for the participant or the legal representative, the case manager, the FMS, MDRS, and the providers.

The IL waiver affords each participant the opportunity to select the personal care attendant of their choice.

The benefit of participant-direction allows the participant to choose a personal care attendant that is proven competent. If a participant knows a particular individual with whom they are comfortable providing their personal care, and that individual meets the requirements as set forth in the IL Waiver, that individual is allowed to provide the direct care for that waiver participant. If a participant knows a particular individual with whom they are comfortable providing their personal care and that person does not meet the requirements as set forth in the IL Waiver, that individual is trained and once qualified is allowed to provide the direct care for that waiver recipient. If a waiver participant does not have a specific personal care attendant, they can select from a list of available, eligible, personal care attendants to provide their care. It is explained to the participant by the case manager/counselor that personal care attendant services will not begin prior to the personal care attendant being certified as competent according to the IL waiver.

If the participant has not located or chosen a personal care attendant within six months after admission to the waiver, or after being without a personal care attendant for six consecutive months, the participant will be reevaluated for the need for waiver services and to determine if the waiver can meet the needs of this participant.

Waiver participants are also allowed to choose qualified vendors of their choice when receiving environmental accessibility adaptations, specialized medical equipment, and transition services.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- (●) **The State does not provide for the direction of waiver services by a representative.**
- ( ) **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- [ ] **Waiver services may be directed by a legal representative of the participant.**
- [ ] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Participant-Directed Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| | | |

| | | |
|---|---|---|
| **Personal Care Attendant** | ☑ | ☑ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C1/C3**

**The waiver service entitled:**
**Financial Management Services (FMS)**

○ **FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

FMS providers hold Medicaid provider agreements with the DOM. The types of entities that will provide FMS will be through vendor organizations via a Medicaid provider agreement. Preferably, the FMS should have a minimum of five (5) years of billing and payroll experience relevant to self-directed medical care. The FMS preferably shall have a working knowledge of disability etiquette, psychological, and social aspects of disability, vulnerable persons act including reporting requirements, home and community based waivers (especially the plans of care) and W-2 employee tax reporting requirements. However if an FMS lacks a working knowledge of disability etiquette, psychological and social aspects of disability, vulnerable persons act and home and community based waivers, training will be provided to ensure the FMS has a solid foundation for working with individuals with disabilities.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers are compensated according to the standardized rate of payment schedule established by DOM.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assists participant in verifying support worker citizenship status**

- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

*Specify:*

The FMS will also furnish the following services:

* verify if the personal care attendant is listed on the Mississippi Nurse Aide Abuse Registry
* verify if the personal care attendant is listed on the Office of Inspector General (OIG) exclusion list
* ensures initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.
* Serves as the participant's employer agent which is the IRS designation of the entity responsible for IRS-related responsibilities on behalf of the participant,
* Provides assistance determining staff wages and benefits,
* Verifies and maintains documentation of employee qualifications, and documentation of services delivered,
* conducts criminal background checks on personal care attendants
* Assist the participant with recruitment of personal care attendants

Supports furnished when the participant exercises budget authority:

- [x] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

*Specify:*

Additional functions/activities:

- [x] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

*Specify:*

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DOM is responsible for oversight of the FMS entities by compliance reviews conducted on an annual basis or more often if needed. Reviews will also be instigated in the event of a complaint regarding management of

funds. MDRS will monitor the care provided by the personal care attendant on an ongoing basis with monthly phone calls to the waiver participant and with face-to-face visits every three months. MDRS case managers/counselors will ensure that personal care attendants are providing the care in accordance with the plan of care and that the plan of care meets the waiver participant's needs. Any underutilization or over utilizations of services will be reported to DOM, the administrative authority.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

Once a waiver applicant has been determined eligible for waiver services, if they require a personal care attendant, the case manager explains the two different choices for personal care services.

1)Participant-Directed personal care service which allows employer and budgetary authority for participants for the personal care attendant service. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a Financial Management Service (FMS) agent to assist with employer and budgetary functions. The waiver participant will have the ability to negotiate salaries and benefits with the personal care attendants while the FMS manages the time sheets, criminal background checks and other employment issues

2)The traditional personal care service, otherwise known as the Co-Participant personal care service, remains a viable choice for those waiver participants who do not desire to be become the employer of record with budgetary control. The Co-Participant choice for personal care service recognizes Mississippi Department of Rehabilitation Services as the employer of record but allows the participant to recruit, hire and terminate employment of personal care attendants. The Co-Participant personal care service does not allow the participant to exercise budgetary authority (excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance).

The FMS is a new support service for the Participant-Directed personal care services providing assistance to the waiver participant with management of the personal care attendant budget and employer duties as associated with the participant being the employer of record. The FMS will submit claims for personal care services to DOM for payment and is responsible assisting the participant with incuding, but not limited to, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance. This choice provides more autonomy and independence for the waiver participant.

The case manager confers with the participant to determine who they would desire to provide their personal care services. After the participant has determined who they would desire, the Rehab counselor/nurse team goes through the specified steps to determine if the requested personal care service provider meets the minimum requirements to be the provider. Once it has been determined that the person meets the requirements, complete training is done with this person, and then as the personal care begins with the participant, ongoing evaluation of the care provided and the satisfaction of the participant is done and alterations, if needed, are made to the plan of care.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|

| | |
|---|---|
| **Financial Management Services** | ☑ |
| **Environmental Accessibility Adaptations** | ☐ |
| **Specialized medical equipment and supplies** | ☐ |
| **Transition assistance services** | ☐ |
| **Personal Care Attendant** | ☐ |
| **Case Management** | ☑ |

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A waiver participant can change from the Participant-Directed Personal Care Service to the Co-Participant Directed personal care service at any time.

Should a participant decide to voluntarily terminate Participant Direction, the participant will communicate this to the case manager. The case manager then will ensure continuity of services are provided in compliance with the approved IL waiver, according to service specifications, and in agreement with the participant's desires, preferences and needs. Additionally, the case manager will continue to monitor the appropriateness of services and frequencies to meet the participant's needs.

## Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Immediate termination of the Participant-Directed personal care service option can occur if the following circumstances arise including, but not limited to:

* The participant's/employer's health or welfare is immediately jeopardized
* The participant's/employer has been convicted of criminal offenses which would preclude him/her from working with the
vulnerable population
* If the participant/employer has not implemented a corrective action that was required to continue Participant-Direction
* The waiver participant cognition declines to the degree that he/she is no longer able to direct his/her own care
* The waiver participant fails to provide adequate justification for underutilizing or over utilizing personal care services

A case manager/counselor will work to assure continuity of services and assure participant health and welfare during the transition period. It is MDRS's responsibility to transition the waiver participant to the Co-Participant personal care service by allowing the participant to recruit and hire their personal care attendant but will lack the budgetary authority.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 50 |
| **Year 2** | | 100 |
| **Year 3** | | 150 |
| **Year 4** | | 200 |
| **Year 5** | | 250 |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Mississippi Department of Rehabilitation Services serves as the common law employer of record with the traditional delivery of personal care services. The participant recruits, hires and can terminate personal care attendants from employment while MDRS maintains the budgetary control.

MDRS performs all necessary payroll and human resource functions of the traditional delivery of personal care services.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☑ **Recruit staff**
- ☑ **Refer staff to agency for hiring (co-employer)**
- ☑ **Select staff from worker registry**
- ☑ **Hire staff common law employer**
- ☑ **Verify staff qualifications**
- ☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Through the reimbursement rate of the FMS, the costs of he criminal background checks will be absorbed.

- ☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☑ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☑ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☑ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Rates for the personal care service are set by the Administrative agency, DOM with input from stakeholders and other interested parties. The amount of the participant's budget is directly related to the individual needs of the waiver participant as identified in the plan of care. The budget is established at a set rate/15 minute unit with the number of units identified in the participant's plan of care multiplied by the set rate for personal care service. With this budget, the waiver participant can negotiate salaries and benefits while still complying with federal and state laws regarding taxes and other required employer costs.

The waiver participant can request an adjustment in the budget amount by consulting with the case manager. Depending on the individual needs of the waiver participant, if an adjustment is denied, the waiver participant will be provided with a notice to a fair hearing.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

**iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The amount allowed for waiver participants is based on the individual needs of the waiver participant in accordance with the plan of care or service plan. DOM sets an established rate for personal care attendant

services billed in 15 minute increments and the waiver participant may bill for personal care attendant services as justified in the plan of care. This method is consistently applied for each waiver participant who chooses the Participant-Directed Model personal care services. This process provides the waiver participant with the greatest level of control over services.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility.** *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

MDRS, the operator of the waiver and the agency providing case management services, will monitor the services being provided to all waiver participants on a monthly basis to ensure that care is being provided in accordance with the plan of care or service plan. The waiver participant is asked to provide details of care provided by the personal care attendant including actual care rendered. An assessment will determine if the care provided is meeting the needs of the waiver participant. On an annual basis or more frequently as required, DOM will review the FMS to determine if monies used coincide with claims presented for payment. The review of the FMS will include a review of claim forms, time logs, billing forms, plans of care and interviews with the waiver participants and care givers.

The FMS agent is required to monitor the service delivery by reviewing the payroll in comparison to the plan of care. The FMS agent must report over or underutilization to the waiver participant and MDRS. When the waiver participant does not correct an over utilization or underutilization, the FMS must notify MDRS and the reason for the continued noncompliance must be determined and corrected. Failing to provide adequate justification for over or underutilization of the personal care service budget may be a reason to involuntarily terminate the Participant-Directed personal care service option.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the

request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Fair Hearing procedures are based on the DOM Administrative Code, Title 23: Medicaid Part 100 Chapter 5: The Hearing Process
A Case Manager sends a Notice of Action (NOA) to the waiver participant by certified mail (Signature return requested).

Contents of Notice of Action include:
a. Description of the action the provider has taken or intends to take
b. Explanation for the action
c. Notification that the consumer has the right to file an appeal
d. Procedures for filing an appeal
e. Notification of consumer's right to request a Fair Hearing, and
f. Notice that the consumer has the right to have benefits continued pending the resolution of the appeal
g. The specific regulations that support, or the change in Federal or State law that requires, the action

The participant or his representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. In an attempt to resolve issues at the lowest level possible, offices should encourage participants to request a local hearing first. The request for a state or local hearing must be made in writing by the participant or his legal representative.

The participant may be represented by anyone he designates. If the participant elects to be represented by someone other than a legal representative, he must designate the person in writing. If a person, other than a legal representative, states that the participant has designated him as the participant's representative and the participant has not provided written verification to this effect, written designation from the participant regarding the designation must be obtained.

The participant has 30 days from the date the appropriate notice is mailed to request either a local or state hearing. This 30-day filing period may be extended if the participant can show good cause for not filing within 30 days.

A hearing will not be scheduled until a written request is received by either the MDRS or the State DOM office. If the written request is not received within the 30 days of the NOA, services will be discontinued. If the request is not received in writing within 30 days, a hearing will not be scheduled unless good cause exists as specificed in the Mississippi Medicaid Administrative Code.

At the local hearing level, MDRS will issue a determination within 30 days of the date of the initial request for a hearing. Although the waiver allows 30 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The participant has the right to appeal a local hearing decision by requesting a State hearing;
However, the State hearing request must be made within 15 days of the mailing date of the local hearing decision.

At the State hearing level, DOM will issue a determination within 90 days of the date of the initial request for a hearing. Although regulations allow 90 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The participant or his representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record. The right to have legal representation at the hearing and to bring witnesses.

2. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.

3. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

Services must remain in place during any appeal process unless the accommodations cannot be made for the safety or threat of harm of the participant or service providers. Upon receipt of the request for a state hearing, the Division of Medicaid,

Bureau of Administrative Appeals will assign a hearing officer.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The types of disputes that can be addressed by an informal dispute resolution process are issues concerning service providers, waiver services, and other issues that directly affect their waiver services. Waiver participants are encouraged to report disputes to their case manager. If a resolution is not reached by the case manager, the issue is reported to the case manager's supervisor. If a resolution is not reached at this level, the issue is reported to the Division of Medicaid. The Division of Medicaid along with the MDRS will collaborate to achieve a resolution. In the event the dispute is with the case manager, MDRS and the Division of Medicaid work with the participant to assign a new case manager. Once a new case manager is assigned, the case manager's supervisor evaluates the participant's satisfaction with the new case manager and notifies the Division of Medicaid of the final resolution. The Division of Medicaid and MDRS are responsible for operating the dispute mechanism. The Division of Medicaid has the final authority over any dispute. The participant is informed by MDRS at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievances and hearing. The participant is given their bill of rights which addresses disputes, complaints/grievances and hearings.

The right to a Fair Hearing is preserved by allowing the participant to request a formal hearing at any time during the informal dispute resolution process unless a formal notice of action has been presented to the participant. Once the notice of action is given to a participant, the participant must follow DOM's Fair Hearing policy.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Division of Medicaid (DOM) and the Mississippi Department of Rehabilitation Services (MDRS) are responsible for operating the grievance and complaint system. DOM has the final authority over any complaint or grievance.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The types of complaints/grievances that can be addressed are complaints/grievances against service providers, complaints /grievances regarding waiver services, and other complaints/grievances that directly affect their waiver services. Waiver participants must first address any complaint/grievance by reporting it to their case manager. The case manager/counselor begins to address the complaint/grievance with the client within 24 hours. If a resolution is

not reached within 72 hours the case manager/counselor reports the complaint/grievance to the supervisor. The supervisor must reach a resolution with the client within seven days. If a resolution is not reached within this time frame it is reported to the Division of Medicaid. The Division of Medicaid along with MDRS will collaborate to achieve a resolution within seven days. In the event the complaint and/or grievance is with the case manager/counselor then MDRS and DOM work with the client. The participant is informed by MDRS at the time they are enrolled in the waiver the specific criteria of a dispute, complaint/grievance and hearing. The participant is given their Appeal Rights which addresses disputes, complaints/grievances and hearings.

Local Hearing- must be requested in writing by the participant or their representative.

State Hearing- must be requested in writing to the Division of Medicaid

# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents are identified as follows:
Abuse (A) -- willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.

Neglect (N) -- can include but is not limited to a single incident of the inability of a vulnerable person living alone to provide for himself, failure of a caretaker to provide what a reasonably prudent person would do.

Exploitation (E) -- Illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person. This can include acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

The Department of Human Services (DHS), Division of Aging and Adult Services is the agency responsible for investigating allegations of A, N, and E. There is a Memorandum of Understanding (MOU) established between DOM and DHS which allows for a free flow of information between the two agencies to ensure the health and welfare of waiver participants.

DOM provides DHS with a list of waiver participants on a monthly basis by which DHS can bump this information against active ongoing investigations to alert DOM of any critical incidents that DOM may not have already been made aware of. The system will make a comparison based of the waiver participant's social security number as a unique identifier.

All reports of abuse, neglect or exploitation are taken very seriously by DOM and MDRS. DOM provides for the reporting and investigating of major and serious incidents of abuse, neglect and exploitation of a waiver participant.

All reports of abuse, neglect or exploitation are to be reported by phone and written report immediately by the appropriate rehab case manager/counselor to their supervisor at the Department of Rehabilitation Services and the Department of Human Services. The potential A, N, or E is also to be reported to the Division of Medicaid/Long Term care as it occurs.

DOM assigns each potential A, N, or E case to a social worker in HCBS to follow up on and report their findings to Administration in HCBS and MDRS managers.

If the waiver participant is at risk for harm or injury related to an unsafe environment, the case manager will call 911 to request immediate assistance. In addition, reports are simultaneously made to the Department of Human Service, the investigative agency in Mississippi who deals with allegations of abuse. DOM and MDRS case managers and social workers follow up with DHS to ensure that reports are investigated and action is taken. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

When participants are initially assessed for the Independent Living (IL) Waiver, they are provided the case manager's name and the phone number. Waiver participants are educated on the definitions of A, N and E and how and when to report such allegations.

The case manager conducts monthly phone contact with each participant and quarterly home visits are made. If there is a concern regarding A, N or E and the participant and /or participant representative has notified the case manager of their concern, a visit can be made at that time to fully assess the situation. The case manager notifies the proper authorities of any A, N, or E allegations.

Division of Medicaid (DOM) shall always be notified of any suspected A, N, or E cases.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

First line entity to receive reports is the Independent Living Rehab case manager.

Second Line Entity is the Division of Medicaid/Long Term Care division.
When the Division of Medicaid receives a complaint, it is immediately assigned to a social worker in HCBS/LTC. The social worker evaluates the case, contacting the appropriate case manager and the social worker at the Department of Human services (DHS) (if one has been assigned).

A visit to the client's home is conducted by the social worker or Medicaid Program Nurse at DOM if the situation warrants.
The communication continues between MDRS, Division of Medicaid, Department of Human Services, and Attorney General's office if necessary, etc., until resolution occurs.

By virtue of Mississippi Code Annotated §43-1-1, et seq. (1972, as amended)' the DHS is authorized to administer the Adult Protective Services Program pursuant to the Mississippi Vulnerable Persons Act § 43-47-1 et seq. of the 1972 Mississippi Code Annotated, as amended. DOM work with DHS through the provision of a memorandum of understanding to assure effective incident management of all home and community based waiver participants under 42 CRFR § 441.302.
As stated in the memorandum of understanding, DHS agrees to provide information on critical incidences involving alleged A, N and E of waiver participants on a monthly basis. Critical incident data will be shared through the use of information technology that will report types of incidents, providers, participant characteristics, results of investigations and the timeliness of investigations. This information is compiled and reviewed by DOM and used to develop strategies to reduce the risk and likelihood of the occurrence of the future incidents.

Mississippi Vulnerable Persons Act, Section 43-47-9 (1). "Upon receipt of a report pursuant to Section 43-47-7 that a vulnerable person is in need of protective services, the department (The Department of Human Services) shall initiate an investigation and/or evaluation within forty-eight (48) hours if immediate attention is needed, or within seventy-two (72) hours if the vulnerable person is not in immediate danger, to determine whether the vulnerable person is in

need of protective services and what services are needed."
As stated in the memorandum of understanding, DHS agrees to provide information on critical incidences involving alleged A, N and E of waiver participants on a monthly basis. Critical incident data will be shared through the use of information technology that will report types of incidents, providers, participant characteristics, results of investigations and the timeliness of investigations. This information is compiled and reviewed by DOM and used to develop strategies to reduce the risk and likelihood of the occurrence of the future incidents.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

MDRS, DOM, DHS and the Criminal Investigative unit of the Attorney General's office all become involved in these cases as needed.

This is an ongoing process, and as these events occur, immediate action takes place and investigation begins
All of the above entities listed keep written records of suspected events of abuse, neglect, and exploitation

The Department of Human Services agrees to provide to DOM information on critical incidences involving alleged abuse, neglect and/or exploitation of waiver participants on a monthly basis. Critical incident data will be shared through the use of information technology that will report types of incidents, providers, participant characteristics, results of investigations, and the timeliness of investigations in order to develop strategies to reduce the risk and likelihood of the occurrence of incidents in the future. Through an interagency agreement, DOM will provide DHS a list of waiver clients on a monthly basis so that a cross reference using a unique identifier can be used to pin point any unreported critical incident involving waiver participants. DOM will review the collected information to reveal any unknown critical incidents. The information revealed as a result of the cross reference will be used to provide intervention on behalf of the waiver participant. Each case will be analyzed on an individual basis to determine the appropriate plan in how to address the issue. The case manager as well as other providers of the waiver participant will be contacted and included in the discussion and development of a plan to address any identified allegation of abuse, neglect or exploitation. DOM will oversee the investigative efforts of DHS to assure the allegation of harm against a waiver participant is thoroughly and completely investigated and that necessary care and services have been provided to prevent further harm or injury.

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

MDRS monitors on an ongoing and continuous basis. Scheduled visits to the participant's home as well as unscheduled visits are made regularly. Unscheduled visits are made randomly to allow the counselor to observe actual activities in the participant's home. If a concern were present, the counselor would visit the participant more often than the required quarterly and would always make unscheduled visits.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use

of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one)*:

**The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

MDRS monitors on an ongoing and continuous basis. Scheduled visits to the participant's home as well as unscheduled visits are made regularly.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

**The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established

concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

i. **Provider Administration of Medications.** *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers

or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  *Complete the following three items:*

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**
***The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance*

*complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**1)Number and percent of participants who have an emergency preparedness plan.**
**Numerator: Number of participants who have an emergency preparedness plan.**
**Denominator: Total number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Compliance Audit**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% +/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| | |

| | |
|---|---|
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**2)Number and percent of participants who receive information on how to report suspected cases of abuse, neglect, or exploitation. Numerator: Number of participants who receive information on how to report suspected cases of abuse, neglect, or exploitation. Denominator: Total number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Compliance Review (Home visit)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% +/-5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**3)Number and percent of complaints that were addressed within required timeframes as specified in the waiver application. Numerator: Number of complaints that were addressed within required timeframes as specified in the waiver application. Denominator: Total number of complaints.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Accessible Automated Case Environment (ACCE)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**4)Number and percent of reported critical incidents that adhere to the timeframes for follow-up as specified in the approved waiver application. Numerator: Number of reported critical incidents that adhere to the timeframes for follow-up as specified in the approved waiver application Denominator: Total number of reported critical incidents**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHS Report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
For Performance Measure (PM) 1, DOM will (a) require case manager to complete Emergency Preparedness Plan as part of the corrective action plan within seven days; and (b) provide training annually.
For PM 2, DOM will (a) require case manager to provide participant with information as part of the corrective action plan within seven days; and (b) provide training annually.
For PM 3, DOM will (a) require unresolved complaints to be resolved within five working days; and (b) address MDRS administrative staff within five working days
For PM 4, DOM will (a) Require immediate follow-up by DHS of the reported critical incident- for those reported critical incidents with no follow-up; (b) Require DHS to develop a corrective action plan within 30 days for those reported critical incidents with late follow-up

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be

available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DOM identified the need for two additional employees (RNs) needed to implement the Quality Improvement Strategy (QIS) for this and other state waivers.

The Division of Medicaid employs staff to assist in system design. Meetings are held routinely, as needed to develop Customer Service Requests (CSRs), review progress, and test system changes. The meetings involve participation from DOM's Bureau of Systems Management, LTC staff and others as may be deemed appropriate depending on the issue for discussion. Meetings with LTC staff, including QA nurses and MDRS staff are held routinely for the purpose of addressing needs and resolving issues.

When the state identifies a system issue, it is reported to the fiscal agent for review and research. System issues that affect services to beneficiaries or affect accurate payment to providers are considered a priority. The State holds monthly meetings with the program staff and the systems staff to address issues that require system changes. Additionally the State has bi-weekly Medicaid Advisory Board (MAB) meetings to identify, correct, and implement system changes to improve the State's ability to adhere to state and federal regulations, policies and procedures

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| | |

| | |
|---|---|
| ☐ **Quality Improvement Committee** | ☑ **Annually** |
| ☐ **Other**<br>Specify: | ☑ **Other**<br>Specify:<br>ongoing; as needed |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Division of Medicaid monitors the Quality Improvement Strategy on an monthly basis. The Quality Improvement Strategy is reviewed annually. The review consists of analyzing aggregated reports and progress toward meeting one hundred (100) percent of the subassurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and MDRS is made to meet waiver reporting requirements. The Quality Assurance (QA) nurses will utilize the Quality Improvement Strategy during all levels of QA activities.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Evaluation of the quality improvement strategy is a continuous and ongoing endeavor. It is reviewed annually to determine if the participants are receiving the highest quality of care possible in the most effective and efficient means possible. The operating agency and DOM will meet quarterly to review the overall waiver operation including the QIS strategy for waiver improvement.

# Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When MDRS is the employer of record for all services including the personal care services:
The MDRS case managers are responsible for reviewing time sheets submitted by each personal care attendant. After review and approval, these are submitted to the MDRS state office staff for further review and verification of accuracy. Once verified, MDRS submits claims for waiver payment via the MMIS Medicaid system.

When the waiver participant is the employer of record for personal care services:
The FMS will assist the waiver participant in reviewing the time sheets submitted by the personal care attendant. After reviewing and approval, the FMS at the direction of the waiver participant, submits the claims for payment via the MMIS Medicaid System.

DOM professional staff also monitor other waiver providers for fiscal accountability through post payment audits of paid claims. Audits are conducted as part of the overall monitoring of the waiver during the compliance review. In instances where claims have been paid erroneously, the provider is notified of any necessary recoupment. The LTC staff also closely review the CMS 372 report for accuracy prior to submittal.

Changes in billing rates, or updates, are discussed in staff meetings and at state-wide in-services. MDRS holds regular training sessions at their facilities to teach staff correct procedures. DOM conducts ongoing training and technical assistance for waiver providers to assure understanding of and adherence with DOM Administrative Codes and reimbursement methodology specified in the waiver.

# Appendix I: Financial Accountability

## Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Financial Accountability**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**1)PM: Number and percent of claims paid in accordance with the reimbursement methodology specified in the approved waiver. Numerator: number of claims coded and paid correctly in accordance with the reimbursement methodology specified in the approved waiver Denominator: total number of claims paid**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**MMIS**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Fiscal Agent | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**2)PM: Number and percent of claims for which payment was made for the service as specified in the waiver Numerator: number of claims paid that included a correct service as specified in the waiver Denominator: total number of claims paid**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**MMIS**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Fiscal Agent | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and** | ☐ **Other** |

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
PM 1 & 2: 1. DOM will recoup money paid erroneously to providers within 30 days of notification; 2. Submit computer systems request (CSR) to fiscal agent within 48 hours of discovery to correct MMIS problems; 3. Report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** | ☐ **Annually** |

Specify:

☐ **Continuously and Ongoing**

☐ **Other**

Specify:

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate Determination Methods: DOM contracted with an actuary firm, Milliman, to thoroughly evaluate the service rates.

To set the context for developing service rates, careful consideration was given for service descriptions and provider handbook information for each waiver service. Educational requirements, expectations, and billable productivity levels were also considered.

Current waiver rates were compared to the same non-waiver Medicaid service rates or a ground up analysis was conducted.
For the Personal Care and Case Management services, initial rates were built from the ground up using the following rating variables:

> Direct service provider salaries and benefits
> Direct service-related expense and overhead costs
> Annual number of hours practitioners are at work
> Percentage of time an at work practitioner is able to convert to billable units (productivity)

The rating variable assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), a proprietary Milliman medical provider compensation survey, and Division of Medicaid and Milliman experience.

Once initial service rates were calculated, a comparison was made of them to the current service rates along with consideration for other aspects of the service provision environment. Projected rates for waiver years following the initial year were based on an expected two (2) percent increase in accordance with the Bureau of Labor Statistics and the Consumer Price Index. Once Milliman completed their rate analysis, DOM solicited public comments on the rates through stakeholder meetings and notification to the tribal government.

Based on the analysis by Milliman along with other consideration, the Division of Medicaid set the first year personal care attendant rate at $4.00/15 minute increment ($16.00 per hour). The rate determination for participant directed personal care service did not differ from the methodology that was utilized when the service is provider managed.

Transitional Assistance rate of $800.00 per lifetime usage was based upon past utilization practices across all waivers. The specialized medical supplies/equipment and Environmental Accessibility Adaptations rates were determined based on previous utilization patterns and current costs. The FMS rate was determined based on analysis of FMS rates for other States in our region with a similar service.

Information about payment rates is made available to waiver participants verbally by the case manager and/or the fiscal management service.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services flow directly from providers to the State's claims payment system (MMIS).

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the

participant's approved service plan; and, (c) the services were provided:

The MMIS houses claims data and information that can be produced upon request. The MMIS system has audit functions to deny payment for services when an applicant is not Medicaid eligible on the date of service. The MMIS system also has an audit function to deny any participant who is not eligible for Medicaid waiver payment on the date of service. That function is the "lock-in", whereby the MMIS system requires a participant to be an approved, eligible Medicaid waiver participant, documented in the MMIS system, in order for the claim to pay. The lock-in function is housed in the MMIS system under the participant file and is performed by Medicaid HCBS staff or the Medicaid Fiscal Agent.
The State conducts post utilization reviews to ensure the services provided were on the participant's approved service plan (plan of care).

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (•) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (•) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

The Mississippi Department of Rehabilitation Services (MDRS)is a State agency. It provides case management, specialized medical equipment and supplies, environmental accessibility adaptations, personal care attendant services and transition assistance services.

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

a) The Mississippi Department of Rehabilitation Services (MDRS);
b) MDRS pays the state match in advance to Division of Medicaid (DOM) via an IGT based on the prior quarter's claims payments.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**
*Check each that applies:*

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
**Do not complete this item.**

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: Nursing Facility**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 33650.00 | 21239.00 | 54889.00 | 56916.00 | 19527.00 | 76443.00 | 21554.00 |
| 2 | 33816.00 | 21663.00 | 55479.00 | 59192.00 | 20308.00 | 79500.00 | 24021.00 |
| 3 | 34077.00 | 22096.00 | 56173.00 | 61560.00 | 21120.00 | 82680.00 | 26507.00 |
| 4 | 34421.00 | 22537.00 | 56958.00 | 64022.00 | 21965.00 | 85987.00 | 29029.00 |
| 5 | 34904.00 | 22987.00 | 57891.00 | 66583.00 | 22843.00 | 89426.00 | 31535.00 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Number Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | Nursing Facility |
| Year 1 | 3500 | 3500 |
| Year 2 | 4000 | 4000 |
| Year 3 | 4500 | 4500 |
| Year 4 | 5000 | 5000 |
| Year 5 | 5500 | 5500 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Based on the CMS 372 Report data for the most recent two (2) years (2010 and 2011) the average length of stay for this waiver is 305 days. Based on this information, it is estimated that average length of stay for waiver participants during the course of the waiver renewal period is approximately ten months.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates for Factor D are based on CMS 372 reports and utilization data from prior years of the Independent Living (IL) waiver.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor D' are based on CMS 372 reports with additional costs added to estimate the impact made by changes in the State Plan (effective April 1, 2012) that allowed for coverage of various medical supplies. This estimate is based on the addition of all services furnished to waiver participants while the particpant is in the waiver

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G are based actual nursing home costs for individuals residing in nursing facilities incluiding those residents with severe orthopedic and neurological disorders.

**iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G" are based on averages of previous years with this waiver population with a 4% increase added each year after the first year for inflation adjustments.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services |
|---|
| **Case Management** |
| **Personal Care Attendant** |
| **Financial Management Services** |
| **Environmental Accessibility Adaptations** |
| **Specialized medical equipment and supplies** |
| **Transition assistance services** |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **5104750.00** |
| Case Management | per month | 3500 | 10.00 | 145.85 | **5104750.00** | |
| **Personal Care Attendant Total:** | | | | | | **97552000.00** |
| Personal Care Attendant | per hour | 3500 | 1742.00 | 16.00 | **97552000.00** | |
| **Financial Management Services Total:** | | | | | | **37500.00** |
| Financial Management Services | per month | 50 | 10.00 | 75.00 | **37500.00** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **9200000.00** |
| Environmental Accessibility Adaptations | per modification | 400 | 2.00 | 11500.00 | **9200000.00** | |
| **Specialized medical equipment and supplies Total:** | | | | | | **5720000.00** |
| Specialized medical equipment and supplies | per item | 1300 | 2.00 | 2200.00 | **5720000.00** | |
| **Transition assistance services Total:** | | | | | | **160000.00** |
| Transition assistance services | per service | 200 | 1.00 | 800.00 | **160000.00** | |
| | | | | **GRAND TOTAL:** | | **117774250.00** |
| | | | | **Total Estimated Unduplicated Participants:** | | **3500** |
| | | | | **Factor D (Divide total by number of participants):** | | **33650.00** |
| | | | | **Average Length of Stay on the Waiver:** | | 10 |

## Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **5950400.00** |
| Case Management | per month | 4000 | 10.00 | 148.76 | **5950400.00** | |
| **Personal Care Attendant Total:** | | | | | | **113717760.00** |
| Personal Care Attendant | per hour | 4000 | 1742.00 | 16.32 | **113717760.00** | |
| **Financial Management Services Total:** | | | | | | **76500.00** |
| Financial Management Services | per month | 100 | 10.00 | 76.50 | **76500.00** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **9200000.00** |
| Environmental Accessibility Adaptations | per modification | 400 | 2.00 | 11500.00 | **9200000.00** | |
| **Specialized medical equipment and supplies Total:** | | | | | | **6160000.00** |
| Specialized medical equipment and supplies | per item | 1400 | 2.00 | 2200.00 | **6160000.00** | |
| **Transition assistance services Total:** | | | | | | **160000.00** |
| Transition assistance services | per service | 200 | 1.00 | 800.00 | **160000.00** | |
| | | | | **GRAND TOTAL:** | | **135264660.00** |
| | | | | **Total Estimated Unduplicated Participants:** | | **4000** |
| | | | | **Factor D (Divide total by number of participants):** | | **33816.00** |
| | | | | **Average Length of Stay on the Waiver:** | | 10 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **6828300.00** |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Case Management | per month | 4500 | 10.00 | 151.74 | **6828300.00** | |
| **Personal Care Attendant Total:** | | | | | | **130440960.00** |
| Personal Care Attendant | per hour | 4500 | 1742.00 | 16.64 | **130440960.00** | |
| **Financial Management Services Total:** | | | | | | **117045.00** |
| Financial Management Services | per month | 150 | 10.00 | 78.03 | **117045.00** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **9200000.00** |
| Environmental Accessibility Adaptations | per modification | 400 | 2.00 | 11500.00 | **9200000.00** | |
| **Specialized medical equipment and supplies Total:** | | | | | | **6600000.00** |
| Specialized medical equipment and supplies | per item | 1500 | 2.00 | 2200.00 | **6600000.00** | |
| **Transition assistance services Total:** | | | | | | **160000.00** |
| Transition assistance services | per service | 200 | 1.00 | 800.00 | **160000.00** | |
| | | | | **GRAND TOTAL:** | | **153346305.00** |
| | | | | **Total Estimated Unduplicated Participants:** | | **4500** |
| | | | | **Factor D (Divide total by number of participants):** | | **34077.00** |
| | | | | **Average Length of Stay on the Waiver:** | | 10 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **7738500.00** |
| Case Management | per month | 5000 | 10.00 | 154.77 | **7738500.00** | |
| **Personal Care Attendant Total:** | | | | | | **147808700.00** |
| Personal Care Attendant | per hour | 5000 | 1742.00 | 16.97 | **147808700.00** | |
| **Financial Management Services Total:** | | | | | | **159180.00** |
| Financial Management Services | per month | 200 | 10.00 | 79.59 | **159180.00** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **9200000.00** |
| Environmental Accessibility Adaptations | per modification | 400 | 2.00 | 11500.00 | **9200000.00** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Specialized medical equipment and supplies Total:** | | | | | | **7040000.00** |
| Specialized medical equipment and supplies | per item | 1600 | 2.00 | 2200.00 | **7040000.00** | |
| **Transition assistance services Total:** | | | | | | **160000.00** |
| Transition assistance services | per service | 200 | 1.00 | 800.00 | **160000.00** | |
| | | | | **GRAND TOTAL:** | | **172106380.00** |
| | | | | **Total Estimated Unduplicated Participants:** | | **5000** |
| | | | | **Factor D (Divide total by number of participants):** | | **34421.00** |
| | | | | **Average Length of Stay on the Waiver:** | | 10 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **8682850.00** |
| Case Management | per month | 5500 | 10.00 | 157.87 | **8682850.00** | |
| **Personal Care Attendant Total:** | | | | | | **165847110.00** |
| Personal Care Attendant | per hour | 5500 | 1742.00 | 17.31 | **165847110.00** | |
| **Financial Management Services Total:** | | | | | | **162360.00** |
| Financial Management Services | per month | 200 | 10.00 | 81.18 | **162360.00** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **9200000.00** |
| Environmental Accessibility Adaptations | per modification | 400 | 2.00 | 11500.00 | **9200000.00** | |
| **Specialized medical equipment and supplies Total:** | | | | | | **7920000.00** |
| Specialized medical equipment and supplies | per item | 1800 | 2.00 | 2200.00 | **7920000.00** | |
| **Transition assistance services Total:** | | | | | | **160000.00** |
| Transition assistance services | per service | 200 | 1.00 | 800.00 | **160000.00** | |
| | | | | **GRAND TOTAL:** | | **191972320.00** |
| | | | | **Total Estimated Unduplicated Participants:** | | **5500** |
| | | | | **Factor D (Divide total by number of participants):** | | **34904.00** |
| | | | | **Average Length of Stay on the Waiver:** | | 10 |